|                                |  |                   | 101  | Indelible Ink. Ensure All<br>partment of Health and Materificate of Death                              | lental Hygie                                   |   | 22501  |
|--------------------------------|--|-------------------|--|--|--|---|--|
| İ                              | Physici  |                   | Decedent's Name (First, Middle, Last)     Charlotte J. Roush   |  | 2. Date of Death<br>Month                      | Day Year 15, 2006                                 | 3. Time of Death 07:15 a. <sup>M</sup>         |
| 100                            | /Medio<br>Examin   |                   | 4a. Facility Name (If not institution, give street and number) Stella Maris  | 4b. City, Town, or Location of Death Timonium  | oury   | 4c. County of Death                               | ore Co.  |
|                                | Funeral<br>Director  |                   | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd:  | Months Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Y<br>Sept. 18 |   | place (State or Foreign<br>ntry)<br>INSYlvania |
|                                | Maryland<br>f show   | ior               | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Maryland Baltimore Co.  | arkville   |  |   | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No         |
|                                | h with the   | al Director       | 10e. Street and Number  11 Joni Court  | 10f. Zip Code 21234  | 10g  | Citizen of What Cou                               |  |
| 036                            | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show say injury or other traumatic event, the Madical Examinar coust be notified at ance. | by Funeral        | 11. Marital Status  12. Was Decedent Ever in U.S. 1 Armed Forces?  1 Never Married 2 Married 1 Yes 2 No  | Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto     □ Yes 2 A No Specify: | ecify Yes or No-<br>Rican, etc.)               | 14. Race - Americ<br>Black, White,<br>Specify: Wh | can Indian,<br>etc.                            |
| Baltimore, Maryland 21215-0036 | ithin 72 hor<br>ne.<br>hen "neturi<br>e Madical I  | Completed         | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)   | ocedent's Usual Occupation<br>live kind of work done during most of work<br>e. DO NOT use retired)     | ing 16   | 6b. Kind of Business/In                           | dustry   |
| d 21                           | ifiled v<br>Hygie<br>other ti  | Be Co             | 12 yrs.  17. Father's Name (First, Middle, Last)   | Homemaker  18. Mother's Name   | e (First, Middle, Ma                           | Own Home  |  |
| ylan                           | Menta<br>Menta<br>arkad<br>atic ev   | To B              | Phenius Charles Bowersox   | Charlo   | tte Est  | er Hackenbe                                       | erg  |
| Mar                            | od 2 should and 27 le m  |                   |  | ailing Address <i>(Street and Number or Rura</i><br>651 Hoerner Avenue                                 |  |   |  |
| lore,                          | iges 1 ar<br>nt of Hear<br>: If Item<br>or othe  |                   | 20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  20b. Place of Discernetery, Commetery, Commetery, Commetery, Commetery, Commeters, Commeter | sposition (Name of Crematory or other place)   | Date 20  | c. Location - City or To                          | own, State                                     |
| Baltin                         | permit. Pa<br>Depertment<br>Important<br>eny injury  |                   | 4 Donation 5 Other (Specify)  21. Signature of Fuperal Service Licensee Michael E. Canapp  | (alley Mem. Gardens 7/1<br>22. Name and Address of Facility<br>Leonard J. Ruck,                        | 53   | Timonium,<br>305 Harford<br>altimore, N           | d Road   |
|                                |  |                   | 23a. Pan1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  |  |  |   | Approximate Interval Between Onset and Death   |
| )                              | Physician<br>/Medical  |                   | Immediate Cause (Final disease or condition resulting in death)  a. CONGESTIVE HEART  Due to (or as a consequence of):   | FAILURE  |  |   |  |
|                                | Examiner   | er                | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):   |  |  |   |  |
| 90,                            | be executed<br>icien and<br>burial-transit   | I Examiner        | causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):  |  |  |   |  |
| 6876                           |  | edica             | d  |  |  |   |  |
| P.O. Box (                     | thet the death certificate be need by the attending physici detached for use es the bu   | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 2 No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown  | 3 Ectopic pregnancy 5 Other (specify)  |  | 23d. Date of delive<br>Month                      | ery<br>Day Year                                |
|                                | law requires thet the<br>as been signed by th<br>2 should be detache   | ð                 | Part II. Other significant conditions continuing to death out not resulting in the   | e underlying cause given in Part I.  |  | cco use contribute to t                           | he cause of death?  pably 4XJUnknown           |
| Division of Vital Records,     | The<br>ete h<br>page   | Completed         |  |  | 24a. Was an autopsy performe                   | prior to co<br>death?                             | psy findings available impletion of cause of   |
| Vita                           | Physician: The this certificate ral director, pag  | Be                | 25. Was case referred to medical examiner?   | Other  | Check only one                                 | TOR .   | HOGDTON  |
| ion of                         | Attending Physic death.  actor: After this by the funeral di   | ation: To         |  | e of 28c. Injury at  | me 5   Residen                                 | ce 6 NOther (Special injury occurred              | y) HUSPICE                                     |
| Divis                          | al or Attend<br>s after death<br>if Director;<br>of in by the f  | Certification:    | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)  | street, factory, office  | 28f. Location (Stre<br>City or Town,           | et and Number or Rura<br>State)                   | al Route Number,                               |
|                                | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funerel Director: Atter th<br>completely filled in by the funeral  | edical C          | 29a. Certifier (Check only one) (Check one) (Check only one) (Check only one) (Check one)  |  |  |   |  |
| )                              | To the within To the comp  | Me                | 29b. Signature and title of certifier  | 29c. License number  |  | 1. Date signed (Month, 7/17/0                     |  |
|                                | 10   |                   | 30. Name and address of person who completed cause of death (Item 23a) (Ty. DR. TARIO MAHMOOD 2300 DULANEY VAI   |  | MD 21093                                       |   |  |
|                                | Sta<br>Regist  |                   | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | -  |  |   |  |
| DH                             | MH 17 Rev 1/2  |                   | JUL 1 9 2006   | year   |  |   |  |

ORIGINAL

|                            |   |                     | 1 - For<br>State<br>Registrar   | State of Mar   |                                    | artmen<br>rtificate                     |                           |                                       | nd Mer                      |  | iene<br>g. No.2 ()             | 06                        | 22502  |
|----------------------------|---|---------------------|---|--|------------------------------------|---|---------------------------|---------------------------------------|-----------------------------|--|--------------------------------|---------------------------|--|
|                            | Physici<br>/Medic   |                     | 1. Decedent's Name (First, Middle, Last) RALPH M.   | ROANE  |                                    |   |                           |                                       | 2.                          | Date of Deat<br>Month                          | 12 3                           | Year<br>2006              | 3. Time of Death<br>0230рм                         |
| )                          | Examir  |                     | 4a. Facility Name (If not institution, give s<br>JOHNS HOPTUNS B  | AYVIEW   |                                    | BHL                                     | TIM                       | ocation of                            | MD                          | ``   | 12101                          | of Death                  | DE CITY  |
|                            | Funeral<br>Director   |                     | 5. Social Security Number 6. Sex 219–26–7399  Usual Residence of Decedent   |  | In yrs. last birthday, Yrs.        | If Under<br>Months                      | Days                      | Hours                                 | Min. 8.                     | Date of Birth<br>(Month, Day,<br>16            | 1939                           | 9. Birthp<br>Cour<br>VA   | lace (State or Foreign<br>try)                     |
|                            | e Maryland<br>ta-f ehow   | ctor                | 10a. State 10b. County MD N/A   | 1  | Oc. City, Town or L<br>Baltim      |   |                           |                                       |                             |  |                                | 1                         | 0d. Inside City Limits 1 ☑ Yes 2 ☐ No              |
|                            | with the  | Dire                | 10e. Street and Number 5200 Bowleys Lane  | 4  |                                    | 10f. Zip                                | Code<br>1206              |                                       |                             | 10   | og. Citizen of USA             |                           | itry?  |
| 036                        | n 72 hours after death with the Maryland<br>"naturel", or Itema 23e or 28e-f ehow<br>adical Examinar must be nutified at    | by Funeral Director |   | 2. Was Decedent Ev.<br>Armed Forces?<br>1 ☐ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates: | er in U.S. 13.                     |   | lent of His<br>offy Cuban | panic Origi<br>, Mexican,<br>Specify: | in? (Specify<br>Puerto Rica | Yes or No-<br>an, etc.)                        | 14. Rad<br>Bla                 | ce - Americ<br>ck, White, | etc.   |
| 21215-0036                 | S 2   | Completed           | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   | ation<br>completed)<br>College (1-4or 5+)  | (Give                              | dent's Usua<br>kind of wor<br>DO NOT us | rk done du                | ion<br>iring most o                   | of working                  |  | 16b. Kind of B                 | lusiness/Ind              | dustry   |
| nd 21                      | E T T T   | Be Cor              | 17. Father's Name (First, Middle, Last)   | N/A  | Coca                               | Cola                                    |                           | 8. Mother                             | 's Name (Fi                 | irst, Middle, N                                | Forkl                          |                           | Operator   |
| Maryland                   | d 2 should be in and Mental   7 le marked o treumatic eve   | ၉                   | Lattie Roa  19a. Informant's Name/Relationship (Typ   |  | 19h Maili                          | no Address                              | (Street ar                |                                       | ene                         |  | nson<br>City or Town,          | State Zin                 | Codel  |
| , Ma                       | 27 le   |                     | Carolyn Roane-wife  |  |                                    |   |                           |                                       | e. Bal                      |  |                                | 212                       | C004)  |
| Jore                       | 0 0   |                     | 20a. Method of Disposition 1 ☐ Burial 2▼ Cremation 3 ☐ Re   | emoval from State  | 20b. Place of Disponentery, cre    | matory or or                            | ther place,               |                                       | Date                        |  | 20c. Location                  |                           | wn, State<br>MD                                    |
| Baltimore,                 | pemil. Pag<br>Department<br>Important: I<br>any njury o   |                     | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License  | 147000   |                                    | 2. Name an                              | d Address                 | of Facility                           | MARG                        | CH FUNI  | Baltin<br>ERAL HO<br>ore, MI   | ME-EA                     | AST  |
|                            | Physician<br>/Medical   |                     | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) | e cause on each line.  | ne death. Do not en                | ter the mode                            | e of dying,               | such as ca                            |                             |  |                                |                           | Approximate<br>Interval Between<br>Onset and Death |
|                            | Examiner  | ner                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                                     | ARRH   | consequence of): YTHM(2            | A                                       |                           |                                       |                             |  |                                |                           | 30 usin  |
| 8760,                      | cate be executed<br>physicien and<br>the burial-transit   | ai Examiner         | Cause (Disease or injury that initiated events resulting in death) Last   | Due to (or as a c  | consequence of):                   |   |                           |                                       |                             |  |                                |                           | years  |
| P.O. Box 687               | death certifi<br>e ettending  <br>id for use as   | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown  | ic. If yes, outcome of<br>1 □ Live birth 2  <br>4 □ Pregnant at tin<br>9 □ Unknown       | Fetal death 3                      | □Ectopic pro<br>□ Other (sp             |                           |                                       | 10                          |  |                                | ite of delive             | ry<br>Day Year                                     |
|                            | 8 E 6   | <u>م</u>            | Part II. Dther significant conditions cont<br>Hypevery  | ributing to death but we head  | not resulting in the u             | nderlying ca                            | ause giver                | in Part I.                            | col-                        |  |                                |                           | e cause of death?<br>ably 4.⊒⊎nknown               |
| Division of Vital Records, | The<br>ete h<br>page  | Completed           | enne Conpert:   | ve hear  | it faile                           | iie                                     |                           |                                       |                             | 24a. Was ar<br>autopsy<br>perform<br>1 □ Yes 2 | red?                           | prior to con<br>death?    | osy findings available inpletion of cause of       |
| Vita                       | Physician: The this certificete ral director, pag   | o Be                | 25. Was case referred to medical examiner?  1. Yes 2 No   | ospital:   | 2 ER/Outpatie                      |   | Other                     |                                       |                             | heck only one                                  |                                |                           |  |
| ion of                     | Attending Phyer deeth. ector: After this by the funeral di  | <b>—</b>            | 27. Manner of Death 1   | 1 ☐ Inpatient  28a. Date of Injury (Month, Day Y   |                                    |   | 8c. Injury a<br>Work?     | 4 🗀 Nurs                              | 28d.                        |  | nce 6 □Oth<br>w injury occur   |                           | ')   |
| Divis                      | ial or Attendi<br>s after deeth.  | Certification:      | 3 Suicide 6 Could not be determined   | 28e. Place of Injury<br>building, etc. (   | / - At home, farm, st<br>(Specify) | reet, factory                           | , office                  |                                       | 28f.                        | Location (Str<br>City or Town,                 | eet and Numb<br>State)         | per or Rura               | Route Number,                                      |
|                            | To the Hospital or Attending within 24 hours after deeth.  To the Funerel Director: After completely filled in by the funer | edicai              | 29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin  | ician: To the best of refer: On the basis of each and manner state                       | xamination and/or in               | h occurred a<br>vestigation,            | at the time<br>in my opii | , date and<br>nion, death             | place, and<br>occurred a    | due to the ca<br>t the time, da                | use(s) and ma<br>te and place, | anner as stand due to     | ated.<br>the cause(s)                              |
|                            | To the To the complet   | Σ                   | 29b. Signature and title of certifier   | MA   |                                    | U                                       | License (                 | 92                                    | LI                          | (  | d. Date signed                 | 106                       | Day, Year)   |
| 2                          |   |                     | 30. Name and address of person who cor  | npleted cause of dear  | th (Item 23a) (Type,               | Print)                                  | ut E                      | m. d                                  | led                         | . It   | (3M)                           | 0                         |  |
|                            | Sta<br>Registr  |                     | 31. Date filed (Month, Day, Year)   | 32. Pegistrar's  | s Signature                        | ast, s                                  |                           |                                       |                             |  |                                |                           |  |

DHMH 17 Rev 1/2001

|                  |  |                  | -   | State of Maryland  |                          |   |                         | nd Mental Hy                                 |               | gible.           |                                  |
|------------------|--|------------------|---|--|--------------------------|---|-------------------------|--|---------------|------------------|----------------------------------|
|                  |  |                  | 1 - For State Registrar   | otato or mary tarre  |                          | rtificate of  |                         |  | Reg. No       | 006              | 22503                            |
|                  | * 1  | · 1              | Decedent's Name (First, Middle, Last  | (1)  |                          |   | -                       | 2. Date of De                                | ath           |                  | 3. Time of Death                 |
| ı                | Physici<br>/Medic  |                  | Do  | nald E. Roone  | ey .                     |   |                         | July 1                                       | Day<br>6, 200 | Year<br>06       | 3:15 A M                         |
| )                | Examin   |                  | 4a. Facility Name (If not institution, give   | street and number)   |                          | 4b. City, Town, o   | or Location of E        | Death  | 4c. Co        | unty of Death    |                                  |
|                  |  | 4                | 2902 West Woodw 5. Social Security Number 6. S  |  | mak de franke ster i i i | Dune<br>If Under 1 Year                                       | dalk                    | Hrs. I a p                                   |               |                  | ore Co.                          |
|                  | Funeral Director   |                  | . 1   | ex 7. Age (In yrs. Ia<br>☑ M 2□ F                          | Yrs.                     | Months Days   |                         | Min. (Month, Da                              | y, Year)      |                  | place (State or Foreign<br>ntry) |
|                  |  |                  | Usual Residence of Decedent   |  |                          |   |                         | Dec. 1                                       | /,193         | / Mar            | yland                            |
|                  | show   | h <sub>a</sub> , | 10a. State 10b. County  | 10c. City,   | Town or Lo               | cation  |                         |  |               |                  | 10d. Inside City Limits          |
|                  | 18a-1  | Director         |   | timore   |                          | Dund  | alk                     |  | 10 011        |                  | 1 ☐ Yes 2 🖾 No                   |
|                  | or death with the Marylan<br>items 23a or 28a-f show<br>or most be notified at                 | D                | 10e. Street and Number  | -11 Dood   |                          | 10f. Zip Code   | 212                     | 222  |               | of What Cou      |                                  |
|                  | Jeath<br>ms 23   | Funeral          | 2902 West Woodw   | 12. Was Decedent Ever in U.S                               | 13.                      | Was Decedent of H   |                         | n? (Specify Yes or No<br>Puerto Rican, etc.) |               | ed Stat          |                                  |
| 9                | or ite   | Fur              | 1 ☐ Never Married 2√2 Married   | Armed Forces?<br>1 ☑ Yes 2 ☐ No<br>If Yes, Give            |                          | f Yes, specify Cuba<br>1 ☐ Yes 2 ☑ No                         |                         | ouerto Rican, etc.)                          |               | Black, White,    | etc.                             |
| 51215-0036       | ours   | d by             | 3 Widowed 4 Divorced  | Year or Dates:   |                          |   |                         |  | Sp            | ecify:           | Mhite                            |
| 2                | i within 72 hours<br>iene.<br>r than "naturs!'<br>ine Medical Ext                              | Completed        | 15. Decedent's Ed<br>(Specify only highest gra  | lucation<br>de completed)                                  | 16a. Dece<br>(Give       | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | ation<br>during most of | f working                                    | 16b. Kind     | of Business/In   | ndustry                          |
| 7                | withi<br>iene.<br>than   | omp              | Elementary/Secondary (0-12)  12 Years   | College (1-4or 5+)   |                          | uck Driv  |                         |  | ጥነነ           | ıckina           | Industry                         |
|                  | Hyge at the  | BeC              | 17. Father's Name (First, Middle, Last)   |  |                          | don brit  |                         | Name (First, Middle,                         |               |                  | <u> </u>                         |
| /lar             | should be<br>nd Mental<br>marked c   | To E             | Paul Rooney   |  |                          |   | Flo                     | orence Kea                                   | ho            |                  |                                  |
|                  | d 2 should<br>th and Mer<br>7 is marke<br>traumatic  |                  | 19a. Informant's Name/Relationship (7   |  |                          |   |                         | or Rural Route Numbe                         | -             |                  |                                  |
|                  | s 1 and<br>if Health<br>item 27<br>other tr  |                  | Mrs. Evelyn D. Ro   |  |                          | sition (Name of   | oodwell                 | L Road Du                                    |               |                  |                                  |
| ב                | 9 ° = 5  |                  | 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐   | Removal from State   | metery, crei             | natory or other plac  | ,                       |  |               | ion - City or To |                                  |
| Baltimore,       | nit. Pag<br>entment<br>ortant:<br>injury c   |                  | 4 □ Denation 5 □ Other (Specify  21. Signature of Funeral Service Licen                                     |  | // -                     | ervice Co   |                         | 19/2006                                      | TOWS          | on, Mar          | ryland                           |
| ğ                | Dep<br>Imp   |                  | 6 hal W   | anffff   |                          | uda-Ruck  | Funera                  | al Home of<br>Dundalk, M                     | Dunda         | alk, In          | nC.                              |
| P                | 13. 25   |                  | 23a. Part1. Enter the disease, or companies shock, or heart failure. List only                              | plications that caused the death.                          |                          |   |                         |  |               | ila zi           | Approximate<br>Interval Between  |
|                  | Physician  |                  | Immediate Cause (Final disease or condition   |  | ratic.                   | Condioi   | 16500                   | ar Diseas                                    | ٥             |                  | Onset and Death                  |
| X .              | /Medical<br>Examiner   |                  | resulting in death)   | Due to (or as a conseque                                   |                          |   |                         |  |               |                  | y gees                           |
|                  | LAGITITIE  | _                | Sequentially list conditions,   | b. — Due to (or as a conseque                              | anno of):                |   |                         |  |               |                  |                                  |
|                  | pet<br>nsit  | nlne             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conseque                                   | erice or):               |   |                         |  |               |                  |                                  |
| ,                | execu<br>n and<br>ial-tra  | Examiner         | that initiated events<br>resulting in death) Last   | Due to (or as a conseque                                   | ence of):                |   |                         |  |               |                  |                                  |
| 760,             | death certificate be executed<br>e attending physician and<br>of for use as the burial-transit | cal              | (   | d  |                          |   |                         |  |               |                  |                                  |
| 9                | es that the death certifica<br>igned by the attending ph<br>be detached for use as th          | Med              | IF FEMALE:  |  |                          |   |                         |  |               |                  |                                  |
| ROX              | ath ce   | Physiclan/Med    | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of pregnan<br>1 Live birth 2 Fetal of | death 3                  | Ectopic pregnancy   | /                       |  | 23d.          | Date of delive   | ery<br>Day Year                  |
| oj.              | he de<br>r the a   | ysic             | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4☐Pregnant at time of dea<br>9☐ Unknown                    | ath 5L                   | Other (specify) _   |                         |  |               |                  |                                  |
| ت <sub>.</sub> ا | requires that the<br>reen signed by th<br>hould be detache                                     | y Ph             | Part II. Other significant conditions of  | ontributing to death but not result                        | ting in the u            | nderlying cause giv   | en in Part I.           | 23e. Did to                                  | bacco use     | contribute to ti | he cause of death?               |
| Hecords,         | quires<br>n sigr<br>uld be   | ed by            |   |  |                          |   |                         | 101  | ′es 2□N       | o 3 Prot         | pably 4 Unknown                  |
| O<br>O           |  | Completed        |   |  |                          |   |                         | 24a. Was                                     |               | 4b. Were auto    | ppsy findings available          |
|                  | The<br>te h  | E O              |   |  |                          |   |                         | — autop<br>perfo<br>1 ☐ Yes                  | rmed?<br>2 No | death?           | mpletion of cause of             |
| VItal            | sien:<br>entifica<br>ctor,   | Be               | 25. Was case referred to medical examiner?  |  |                          |   | 26. Place of            | Death (Check only o                          |               |                  | 7                                |
| 5                |  | ဥ                | 1 Yes 2 No  | · · · · · · · · · · · · · · · · · · ·                      |                          | t 3 DOA Oth   | 4 🗆 Nursii              |  |               | Other (Specif    | y)                               |
|                  | Jing F<br>After<br>funer   | lon:             | 27. Manner of Death  1 Selatural 5 □ Pending  | (Month, Day Year)  | 28b. Time of<br>Injury   | Wor   | k?                      | 28d. Describe h                              | low injury oc | curred           |                                  |
| DIVISION         | Attending in death.  | ficat            | 2 Accident investigation 3 Suicide 6 Could not be   |  | ne. farm. str            |   | Yes 2 □No               |  | Street and N  | umber or Rura    | al Route Number,                 |
| 5                | - to -   | Certification:   | 4 Homicide determined   | building, etc. (Specify)                                   |                          | out, reasony, outdoor   |                         | City or Tox                                  | m, State)     |                  |                                  |
|                  | To the Hospitel of within 24 hours af To the Funerel D completely filled in                    |                  | 29a. Certifier 1 Certifying Ph  | ysician: To the best of my know                            | ledge, death             | occurred at the tir   | ne, date and p          | place, and due to the                        | ause(s) and   | d manner as s    | tated.                           |
|                  | To the H<br>within 24<br>To the F<br>complete  | Medical          | one)  | niner: On the basis of examination and manner stated.      | on and/or in             |   |                         |  |               |                  |                                  |
|                  | Son Con  | 2                | 29b. Signature and title of certifier   | 1 . 17   |                          | 29c. Licens   | e number                | 7  | 29d. Date si  | gned (Month,     | Day, Year)                       |
|                  | OY   |                  | I W   | ) Depaty   |                          | DI S  | 100                     |  | day           | 112              | 006                              |
| 5                |  |                  | The many and address of person who  | 11 1111  | 23a) (Type.              | S Hill  | CT Lut                  | Herville                                     | Mi            | 1 21             | 093                              |
|                  | Sta  | te               | 31. Date filed (Month, Day, Year)   | 32. Registrar's Signatu                                    |                          | × ',  | -, -,                   | 20,0,010                                     | /             | 101              |                                  |
|                  | Reaistr  | ar               | .1111 1 9 2000  | Han K  | Cora                     | 103   |                         |  |               |                  |                                  |

DHMH 17 Rev 1/2001

|            |  |                 | 1 - For<br>State<br>Registrar   | State of                                | Maryland                                   |                 | artment of<br>rtificate of            |                              |                        |                                  | giene<br>Reg. No.2   | 006                                    | 225(                                 | 04               |
|------------|--|-----------------|---|---|--|-----------------|---------------------------------------|------------------------------|------------------------|----------------------------------|----------------------|--|--------------------------------------|------------------|
| П          | Physicia   | an              | 1. Decedent's Name (First, Middle, Last)  |   |  |                 | ·                                     |                              |                        | 2. Date of Dea                   | Day                  | Year                                   | 3. Time of De                        |                  |
|            | /Medic   | al              | Paul Wayne  |   |  |                 | 45 City Town                          | 1                            | - 1 Death              | July                             | 12,                  | 2006                                   | 5:00 P                               | М                |
|            | Examin   | er              | 4a. Facility Name (If not institution, give : 44 W. Talbot Str  |   | er)  |                 | 4b. City, Town,                       | or Location o<br>Brookli     |                        |                                  | 4c. Cot              | unty of Death                          |                                      |                  |
| Н          | Funeral  |                 | 5. Social Security Number 6. Sex  | 7.                                      | Age (In yrs. I                             | ast birthday)   | If Under 1 Yea                        | r If Under                   | 24 Hrs.                | 8. Date of Birt                  | h<br>Voorl           |  | place (State or F                    | oreign           |
| п          | Director   |                 | 214-54-4925   | M 2□F                                   | 56   | Yrs.            | Months Days                           | s Hours                      | Min.                   | May 7,                           | 1950                 | M                                      | place (State or Forty)<br>aryland    |                  |
|            | and<br>w   |                 | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City                                  | , Town or Lo    | cation                                |                              |                        |                                  |                      |  | 0d. Inside City I                    | Limits           |
|            | Mary<br>Ind  | ţō              | Maryland N/A  |   |  |                 | Brookl                                | un.                          |                        |                                  |                      |  | 1 💢 Yes 2                            | □No              |
|            | th the<br>or 28s   | Funeral Directo | 10e. Street and Number  |   |  | ·               | 10f. Zip Code                         |                              |                        |                                  | 10g. Citizen         | of What Cou                            | ntry?                                |                  |
|            | ath will   | raiD            | 44 W. Talbot Stre   | et                                      |  |                 |                                       | 1225                         |                        |                                  |                      | . s. A                                 | •                                    |                  |
|            | er de  | une             |   | 12. Was Decede                          | es?  | S. 13. \        | Was Decedent of<br>If Yes, specify Cu | Hispanic Ori<br>ban, Mexicar | gin? (Spe<br>1, Puerto | ecify Yes or No-<br>Rican, etc.) | - 14.                | Race - Ameri<br>Black, White,          |                                      |                  |
| 35         | urs aft  | by              | 1 ☐ Never Married 2 ☐ Married ☐ 3 ☐ Widowed 4 💢 Divorced  | 1 Ves 2<br>If Yes, Give<br>Year or Date |  |                 | 1□Yes 2X N                            | o Specify:                   |                        |                                  | Spe                  | ecify:                                 | rite                                 |                  |
| 215-0036   | be filed within 72 hours after death with the Maryland all Hyglene. I all Hyglene. I of ther than "natural", or items 23s or 28s-f show event, the Madical Examiner must be notilised at | Completed       | 15. Decedent's Edu<br>(Specify only highest grade   | cation                                  |  | 16a. Dece       | dent's Usual Occi                     | upation                      | t of worki             | na                               | 16b. Kind o          | of Business/In                         |                                      |                  |
| 7          | ne.<br>han "   | mpie            | Elementary/Secondary (0-12)   | College (1-4                            | or 5+)                                     | life.           | DO NOT use retir                      | red)                         | C OF WORK              | 9                                | τ                    |  |                                      |                  |
| 7          | filed w<br>Hygier<br>other th  |                 | 12th Grade  17. Father's Name (First, Middle, Last)   |   |  |                 | Inver                                 |                              | er's Name              | (First, Middle,                  |                      | p Agen                                 | сy                                   |                  |
| aŭ         | ental<br>ked c   | To Be           | Paul T. Rabey   |   |  |                 |                                       |                              |                        | trey we                          |                      |  |                                      |                  |
| Maryland   | s 1 and 2 should be<br>if Health and Mental<br>item 27 is marked of<br>other traumatic eve   | -               | 19a. Informant's Name/Relationship (Ty  | pe, Print)                              |  | 19b. Mailir     | ng Address (Stree                     | et and Numbe                 |                        |                                  |                      | wn, State, Zip                         | Code)                                |                  |
|            | rt 2   |                 | Marguerite N. Cus   | imano (:                                |  |                 | 3 Shamro                              |                              | 2., B                  | altimor                          | Le, Md               | . 2120                                 | 6                                    |                  |
| Baltimore, | Pages 1 ar   |                 | 20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ F   | lemoval from St                         | ate  |                 | sition (Name of<br>matory or other pi | lace)                        |                        | )ate                             |                      | on - City or To                        |                                      |                  |
| E          | permit. Pages of Department of Himportant: If Ite eny injury or of page.   |                 | * 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License  |   | Ва   |                 | Cremato                               | ry !                         | 1113                   | 106                              | Baltin               | nore. I                                | laryland                             | <u>1</u>         |
| Ra         | Depa<br>Depa<br>Impo<br>eny ii   |                 | 21. Signature of Furieral Service Licens  | el l'e                                  | 1  |                 | 2. Name and Add<br>331 Brek           |                              |                        |                                  |                      |  |                                      |                  |
| 10         | \$ 34  | _               | 23a. Part1. Enter the disease, or compl<br>shock, or heart failure. List only or  | ications that cau                       | ised the death                             |                 |                                       |                              |                        |                                  |                      |  | Approximate<br>Interval Between      |                  |
|            | Physician  |                 | Immediate Cause (Final disease or condition   |   |  | CANC            | 1400 m                                | 4 6                          | -                      | Rusy                             | akor                 |  | Onset and Dea                        |                  |
| byc.       | /Medical<br>Examiner   |                 | resulting in death)   |   | as a consequ                               |                 |                                       |                              |                        |                                  |                      |  |                                      | -                |
|            | Examine.   | -               | Sequentially list conditions,   | Due to (or                              | as a consequ                               | ience of):      |                                       |                              |                        |                                  |                      |  |                                      |                  |
| <b>D</b> - | uted<br>J<br>ansit   | Examiner        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |   |  |                 |                                       |                              |                        |                                  |                      |  |                                      |                  |
| ĵ          | ate be executed<br>hysicien and<br>the burial-transit  |                 | resulting in death) Last  | Due to (or                              | as a consequ                               | uence of):      |                                       |                              |                        |                                  |                      |  |                                      |                  |
| 8760,      | certificate be executed inding physicien and use as the burial-transit   | licai           |   | d                                       |  |                 |                                       |                              |                        |                                  |                      |  |                                      |                  |
| Θ<br>×     | eath certifica<br>attending ph<br>for use as t   | Physician/Med   | IF FEMALE:  | 3c. If yes, outco                       | me of precipa                              | ncv             |                                       |                              |                        |                                  |                      |  |                                      | 7.77             |
| Rox        | atter<br>for u   | cian            | 23b. Was decedent pregnant in the past 12 months?   | 1 Live birt                             | h 2 ☐ Fetal                                | death 3         | Ectopic pregnan Other (specify)       | су                           |                        |                                  | 23d.                 | Month                                  | ory<br>Day Yea                       | ar               |
| J.         | at the de<br>by the a  | hysi            | 9 Unknown   | 9□ Unknow                               | m  |                 |                                       |                              |                        |                                  |                      |  |                                      |                  |
|            | gned<br>go de  | by P            | Part II. Other significant conditions con   | ntributing to dea                       | th but not resu                            | ulting in the u | nderlying cause g                     | given in Part I.             |                        |                                  |                      |  | ne cause of deal                     |                  |
| ecords,    | w require<br>been sig<br>should b  | Completed       |   |   |  |                 |                                       |                              |                        | 101                              | ′es 2□N              | o 3 Prot                               | ably 4 Nunk                          | inown            |
| Rec        | The law<br>ate has b<br>page 2 si  | mple            |   |   |  |                 |                                       |                              |                        | 24a. Was<br>autop                | an 24<br>sy<br>rmed? | tb. Were auto<br>prior to co<br>death? | psy findings ava<br>mpletion of caus | ailable<br>se of |
|            | olcian: The<br>certificate his<br>rector, page   | e Co            | 25. Was ones referred to medical  |   |  |                 |                                       |                              |                        | 1 ☐ Yes                          | 200 No               | 1 Yes                                  | 2 No                                 |                  |
| 5          | yelcian:<br>is certific<br>director,   | 0 8             | 25. Was case referred to medical examiner?  1 Yes 2 No  | fospital:                               | natient 2 🗆                                | ER/Outpatien    | nt 3 DOA                              | lthor                        |                        | ne 5 Resid                       | Sec. 1               | Other (Specif                          | 5 (55)                               |                  |
| בס ר       | ding Phye<br>h.<br>After this<br>funeral di  | T:u             | 27. Manner of Death   | 28a. Date of (Month,                    |  | 28b. Time of    |                                       |                              |                        | 28d. Describe h                  |                      |  | 9)                                   |                  |
| <u> </u>   | Attendir<br>death.<br>ctor: Af<br>y the fur  | catic           | 1 Natural 5 Pending 2 Accident investigation  | (                                       |  | ,,              |                                       | Yes 2                        | No                     |                                  |                      |  |                                      |                  |
| Division   | or Att   | Certification:  | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined   | 28e. Place o<br>building                | f Injury - At ho<br>, etc. <i>(Specify</i> | me, farm, str   | eet, factory, office                  | Э                            |                        | 28f. Location (S<br>City or Tow  |                      | umber or Rura                          | i Route Number                       | r,               |
|            | To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,                          |                 | 29a. Certifier 1 Certifying Physics   | sician: To the b                        | est of my know                             | wiedge, deat    | h occurred at the                     | time date an                 | d place a              | and due to the                   | rause(s) and         | I manner as s                          | tated                                | -                |
|            | n 24 h   | Medical         | (Check only 2 Medical Exami   | ner: On the bas<br>and manne            | is of examinat                             | tion and/or in  | vestigation, in my                    | opinion, dea                 | th occurr              | ed at the time,                  | date and pla         | ce, and due to                         | the cause(s)                         |                  |
|            | To the vithing to the comp   | Σ               | 29b. Signature and title of certifier   |   |  |                 |                                       | nse number                   |                        |                                  | 29d. Date sig        | gned (Month,                           | Day, Year)                           |                  |
|            |  |                 | 13. K. J.   | Luf                                     | 1 -  | 9               |                                       | 2807                         | 7                      |                                  | 7/1                  | 4/2                                    | 006                                  |                  |
|            | 5  |                 | 30. Name and address of person was co   |   |  |                 |                                       | 57                           | 0                      | & (Ten                           |                      |  | > 2120                               | ~                |
|            | Sta  | te              | 31. Date filed (Month, Day, Year)   | 32. Reg                                 | gistrar' Signal                            | TUP MARKE       | NEENP                                 | -/.                          | D:                     | 2116                             | -0 W.Z               | " we T                                 | 2120                                 | 1                |
|            | Registr  |                 | 1111 1 9 2006   | Berew                                   | 85° 1                                      |                 |                                       |                              |                        |                                  |                      |  |                                      |                  |

|  | State of Maryland / Department of State of Maryland / Certificate   | of Health and M  | lental Hygiei<br>Reg.                         | ne 006  | 22505   |
|--|---|--|---|---|---|
| Physician  | 1. Decedent's Name (First, Middle, Last)  George E. Sims, Jr.   |  | 2. Date of Death Junoph 18.                   | Da 2006 Year                                    | 3. Time of Death 2:09 A. M                    |
| /Medical<br>Examiner   |   | own, or Location of Death  |   | 4c. County of Death                             |   |
| LAdillile  | 1003 Somerset Drive   | Glen Burnie  |   | Anne Aru  | ndel  |
| Funeral<br>Director  | 214-10-4202 (4.11-2) (5) (75.   | Year If Under 24 Hrs.<br>Days Hours Min.                               | 8. Date of Birth<br>April 10,                 | <sup>ar</sup> 1921 Mar                          | place (State or Foreigr<br>Pland              |
| land land  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location   |  |   |   | 10d. Inside City Limits                       |
| Mary<br>Nation   | Maryland Anne Arundel Glen Burnie   |  |   |   | 1 ☐ Yes 2 No                                  |
| vith the Ma<br>or 28a-1 •<br>be notified   | 10e. Street and Number 10f. Zip Co  | ode  | 109.  | Citizen of What Cou                             | intry?  |
| ath w  |   | 21061  |   | nited Sta                                       |   |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydione. Department of Health and Mental Hydione.  any injury or other treumatic event, the Medical Examinar must be notified at once.  To Be Completed by Funeral Director  | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No  1 □ Yes, Specify  1 □ Yes, Sque  1 □ Yes 2 □ No   | nt of Hispanic Origin? (Spe<br>y Cuban, Mexican, Puerto<br>No Specify: | ecify Yes or No-<br>Rican, etc.)              | 14. Race - Amer<br>Black, White<br>Specify: Whi | etc.  |
| 2 hou  | 15. Decedent's Education 16a. Decedent's Usual C  | Occupation   | 16b   | . Kind of Business/l                            | ndustry                                       |
| ed within 72 ho<br>ygiene.<br>ner then "natur<br>it, the Medical<br>Completed  | Figmentary/Secondary (U-12)   College (1-40r 5+)  | done during most of working retired)                                   |   | 11 0  |   |
| Hygier Hygier Cor  | 17. Father's Name (First, Middle, Last)   | 8  |   | deral Gov                                       | ernment                                       |
| ould be fi<br>Mental H<br>varked ott<br>vatic ever   | George E. Sims, Sr.   | Ida  | (First, Middle, Maid<br>Schaener              |   |   |
| d 2 sh<br>th and<br>treum<br>treum   | 19a. Informant's Name/Relationship (Type, Print)  Emma J. Sims / Wife  1003 Somers  | Street and Number or Aura  | l Route Number, Ci<br>len Burnie              |   |   |
| Heal<br>Heal<br>Hem 2<br>other   | 20a. Method of Disposition  20b. Place of Disposition (Name cametery, crematory or other  |  |   | Location - City or T                            |   |
| Pages<br>ient of<br>nt: If i   | 1 🖺 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donatjon 5 □ Other (Specify) Glen HAven Mem.  | 1  |   | len Burni                                       | e. MD   |
| Departm<br>Departm<br>Importa<br>any nju   | 21. Signature of Funeral Pervise Licensee 22. Name and A  | Address of Facility Ruddick Fun  |   |   | 21061   |
| Incate be executed by physicien and street burial-transit and the burial-transit edical Examiner   | 23a. Part1. Enter the disease, or complif ations that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  | ophageal   | Concu   | nona  | Interval Between Onset and Death Y L L S      |
| uttending<br>or use a  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnant at time of death   5   Other (special pregnant at time of death   5 |  |   | 23d. Date of delik<br>Month                     | rery<br>Day Year                              |
| w requires thet the de been signed by the a should be detached full the should be detached full the should be by by should be by by should be shou | Part II. Other significant conditions contributing to death but not resulting in the underlying cause   | se given in Part I.  | 23e. Did tobacc                               | co use contribute to                            | the cause of death?                           |
| stcien: The law requir<br>certificate has been si<br>rector, page 2 should<br>be Completed   |   |  | 24a. Was an autopsy performed                 | ? prior to co                                   | opsy findings available ompletion of cause of |
| centific<br>ector,<br>Be   | 25. Was case referred to medical examiner?  | 26. Place of Death   |   |   |   |
| ith.  After this of tuneral direction: To  | 1   Yes   2   No  |  | ne 5 € Residence<br>28d. Describe how in      |   | rfy)  |
| To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the Ampletely filled in by the tuneral Medical Certification:   | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)  | office 2   | 28I. Location (Street<br>City or Town, St     | and Number or Rui<br>ate)                       | ral Route Number,                             |
| To the Hospital or At within 24 hours after of To the Funeral Direct Completely filled in by Medical Certifl   | 29a. Certifier (Crieck only one)  1 Certifying Physician: To the best of my knowledge, death occurred at 1 Limited and 2 Limited Examiner: On the basis of examination and/or investigation, in and manner stated.  | The time, date and place, a my opinion, death occurre                  | and due to the cause<br>and at the time, date | e(s) and manner as<br>and place, and due        | stated,<br>to the cause(s)                    |
| To T   |   | icense number  | 4   | Date signed (Month                              | , Day, Year)                                  |
| 10   |   | 0003329  | 6 Ju  | ly 18, 20                                       | 06  |
| 10   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Neil Padgett, M.D. 7711 Quarterfield Rd   | Glen Rurni   | e. MD 21                                      | .061  |   |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)  JUL 1 9 2006  32. Refistrar's Signature  |  | .c, 1111 21                                   | .001  |   |

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Sperke

| ry Shipman   |                |   | artment of Health and Mental H  | vaiene               |  |     |
|--|----------------|---|---|----------------------|--|-----|
|  |                |   | rtificate of Death  |                      | 2006 225   | 5 ( |
| Physicia<br>edical Examin  | in/            | 1 Decedent's Name (First, Middle Last)  |   | 2 Date of Death      | Day Year   |     |
| 7  |                | 4a. Facility Name (if not institution, give street and number) Sinai Hospital   | 4b. City, Town, or Location of Death  |                      | 4c. County of Deati  |     |
| Funeral  |                | 5 Social Security Number 6 Sex 7. Age (In yrs   |   | 8. Date of Birth     | (MM/DD/YYYY) 9. Birthplace (State or                       |     |
| Director   |                | 215.08.3707 1XM 2 F 2   | Yrs. Months Days Hours Mir  |                      | 1977 Foreign Country) M.D                                  |     |
| any  |                | Usual Residence of Decedent  10a. State 10b. County 10c. City   | , Town or Location  |                      | 10d. Inside City Limi                                      | its |
| * *  | ۲              | MD Ba   | Itimore   |                      | 1 Yes 2 N  | Vo  |
| Aaryla<br>28a-f<br>1 at or   | Director       | 10e. Street and Number  | 10f. Zip Code   | 10                   | g Citizen of What Country?                                 |     |
| D 21215-0036<br>should be filed within 72 hours after death with the Maryland<br>and Mental Hygiene<br>7 is marked other than "natural", or items 23a or 28a-f show a<br>ratic event, the Medical Examiner must be notified at once.   | al Dir         | 11. Marital Status 12. Was Decedent Ever in U   | J1344<br>I.S. 13. Was Decedent of Hispanic Origin? (S   | pecify Ves or No-    | 14. Race - American Indian, Black,                         |     |
| eath w   | Funeral        | 1 Never Married 2 Married Armed Forces? 1 Yes 2 No  | If Yes, specify Cuban, Mexican, Puerto  | Rican, etc.)         | White, etc.  |     |
| after de al", or   | by F           | 3 Widowed 4 Divorced If Yes, Give Year or Dates:  | 1 Yes 2 No specify:   |                      | Specify Black  |     |
| hours<br>natur<br>Exam   | edt            | 15. Decedent's Education (Specify only highest grade completed)   | 16a. Decedent's Usual Occupation (Give kind of<br>during most of working life. DO NOT use ret |                      | 16b. Kind of Business/Industry                             |     |
| )36<br>thin 72 hours af<br>ne.<br>than "natural<br>edical Examin   | Completed      | Elementary/Secondary (0-12) College (1-4 or 5+)   | COOK  |                      | Earleanin  |     |
| 5-0036 Iled within 7 Hygiene I other than  | E              | 17. Father's Name (First, Middle, Last)   |   | (First, Middle, Ma   | #OOd Service aiden Surname)                                | _   |
| 21215<br>uld be file<br>Mental H<br>marked o   | a              | Gary Shipman 51.  19a. Informant's Name/Relationship (Type, Print')   | 19b. Mailing Address (Street and Number or  | ina wa               | ashing ten   |     |
| and 2 should be filed within 72 hours after and 2 should be filed within 72 hours after leath and Mental Hygiene from 27 is marked other than "natural" transmatic event, the Medical Examine  | ٤              |   | Hills 11  |                      |  |     |
| Z p d Z l l  |                | Iryalah V. Shipman / Wife  20a. Method of Disposition  20b.   | Place of Disposition (Name of cemetery,   | ultimere Date        | 20c. Location - City or Town, State                        |     |
| altimore, M<br>rmit Pages I and 2<br>gartment of Health a<br>prortant: If item 2   |                | 1   Burial 2   Cremation 3   Removal from State   | crematory or other place)   | ,                    | Battimore mD   |     |
|  |                | 4 Donation 5 Other Specify: 21 Signature of Funeral Service Licenses  | 22. Name and Address of Facility  |                      | Extere Junion Service                                      | 2   |
| Balt<br>permit<br>Departi<br>Import<br>injury  |                | Vanthu C. ( )   | 8728 Liberty 12ct   | Randall              | How MD 21133   |     |
| Physician<br>/Medical  |                | 23a Part I. Enter the disease, or complications that caused the death<br>failure. List only one cause on each line.                   | n. Do not enter the mode of dying, such as cardiac of   | or respiratory arres | st, shock, or heart Approximate Interv<br>Between Onset an |     |
| Examiner   |                | Immediate Cause (Final disease or condition resulting in death)  a Multiple Stab Wounds  Due to (or as a consequence or               | <b>(</b> \$).   |                      | Death  |     |
| <i>#</i>   |                | Sequentially list conditions.   | JI).  |                      |  |     |
|  | iner           | if any, leading to immediate cause. Enter Underlying Cause  Due to (or as a consequence of  | of):  |                      |  |     |
| T iii  | Examine        | (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of                                     | of):  |                      |  |     |
| be executed sician and unial - transit   | dical E        | · d   |   |                      |  | _   |
| 50,<br>te be e<br>tysician   | <b>l</b> edic  | UNPENDED X AMENDED 1tem#28  IF FEMALE. 23c If yes, outcome of pres  | b and 28e, perME, g859,9/1/200  | 6 TT                 | 22d Date of delivery                                       |     |
| tox 68760<br>eath certificate be<br>e attending physic<br>for use as the bu  | sician/Me      | 23b. Was decedent pregnant in the past 12 months?   | 2 Fetal death 3 Ectopic pregna  | ancy                 | 23d. Date of delivery  Month Day Year                      |     |
| Box 6876<br>e death certificate<br>the attending phy<br>ed for use as the b  | ysici          | 1 Yes 2 No 9 Unknown 9 Unknown  | eath 5 Other (Specify)  |                      |  |     |
| P.O. E es that the digned by the detached  | y Phy          | Part II. Other significant conditions contributing to death but not   | resulting in the underlying cause given in Part I.  | 23e Did tob          | pacco use contribute to the cause of death?                |     |
| S, P.C<br>uires that<br>n signed l   | ed by          |   |   |                      | 2 No 3 Probably 4 V Unknown                                |     |
| Vital Records hysician: The law requi this certificate has been al director, page 2 should   | Completed      |   |   | 24a Was ar<br>autops | y prior to completion of cause of                          |     |
| Rec<br>The I<br>ficate I   | Con            |   |   | perform<br>1 Yes 2   |  |     |
| Vital Recysician: The line certificate ligitate director, page   | Be             | 25. Was case referred to medical examiner?  | 26 Place of Death (Check ER/Outpatient 3 DOA Other Nursi                                      |                      | Residence 6 Other;   |     |
| n of V<br>ling Phys<br>After thi<br>funeral d  | .: To          | 27. Manner of Death 28a. Date of Injury   | 28b. Time of Injury 28c. Injury at Work?  | 28d Describe ho      | ow injury occurred   |     |
| ion<br>Itendin<br>Ieath<br>Itor: A   | atior          | 1 Natural 5 Pending Jul (12, 2006) 2 Accident Investigation   | 0000 hrs 1 Yes 2 ✓ No   | Subject was          | stabbed  |     |
| Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b | Certification: | 3 Suicide 6 Could not be  | nome, farm, street, factory, office building, etc.  | or Town, Sta         | treet and Number or Rural Route Number, Cilate)            | ty  |
| Lospita<br>4 hours<br>7 unera  |                | 29a. Certifier  | tet at residence  dge, death occurred at the time, date and place, and                        |                      | n Avenue, Baltimore, MD                                    | _   |
| To the Hos<br>within 24 h<br>Fo the Fun<br>completely  | Medical        | (Check only one) 2 Medical Examiner: On the best of my knowled one) 2 Medical Examiner: On the basis of examination and manner stated |   |                      |  |     |
| F 3 F 3  | Me             | 29b. Signature and title of certifier   | , 29c. License number   |                      | 29d. Date signed (Month, Day, Year)                        | _   |
|  |                | Aphra Brassell MD.  | O.C M.E.  |                      | July 13, 2006  |     |
| h  |                | Mame and address of person who completed cause of death (Iter     Melissa Brassell, MD  |   | 21201                |  |     |
| S  | tate           | 31. Date filed (Month, Day, Year)  32. Registrar's Signar   |   |                      |  | _   |
| Regis  |                | 44 4 0 0000   | Craste )  |                      |  |     |

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| 05116<br>hard Smith, .   | Jr.              | St   | Please Ty<br>ate of Maryland  |                 |                                      | k Indelible In<br>Ith and Menta          |                                      | 0.0                               |   |
|--|------------------|--|---|-----------------|--------------------------------------|--|--------------------------------------|-----------------------------------|---|
|  |                  | 1- For State<br>Registrar  |   | Certi           | ficate of Dea                        | th                                       |                                      | g NO                              | 06 2250                                   |
| Physicia<br>dical Exami  |                  | Decedent's Name (First, Middle Control of the |   |                 |                                      |  | 2. Date of Deat<br>Month             | Day Year                          | 3 Time of Death<br>2323 hrs               |
|  |                  | RICHARD A. SMI  4a. Facility Name (if not institution  |   |                 | 4b. City,                            | Town, or Location of I                   | July 16, 20<br>Death                 | 4c. County of De                  |   |
|  |                  | Sinai Hospital   |   |                 | Balti                                | more                                     |                                      |                                   |   |
| Funeral  |                  | 5. Social Security Number  | 6. Sex 7. Ag  | e (In yrs. last |                                      | der 1 Year   If Under 2<br>hs Days Hours |                                      |                                   | Birthplace (State or<br>eign              |
| Director   |                  | 219-82-1997  | 1× M 2 F  | 34              | Yrs. Mont                            | hs Days Hours                            | Min. 11/02/                          |                                   | Country) MD                               |
| any  |                  | Usual Residence of Decedent  10a, State 10b, County  |   | 10c. City. To   | own or Location                      |  |                                      |                                   | 10d. Inside City Limits                   |
| 3  |                  | MD   |   |                 | BALT                                 | MODE                                     |                                      |                                   | 1 X Yes 2 No                              |
| larylar<br>8a-f s  | Director         | 10e. Street and Number   |   |                 |                                      | p Code                                   | 10                                   | g Citizen of What C               | ountry?                                   |
| th the Maryland  23a or 28a-f show notified at once,   |                  | 3715 PARK HEIG   | HTS AVE.  |                 |                                      | 21215                                    |                                      | U.S.A.                            |   |
| n with<br>ms 23<br>be no   | eral             | 11. Marital Status   | 12. Was Decedent  |                 |                                      |  | ? ( Specify Yes or No-               |                                   | nerican Indian, Black,                    |
| r death wi<br>or items   | Fun              |  | 1 Yes 2   | X No            |                                      | _  | deno mean, etc.)                     |                                   |   |
| rs afte<br>ural".  | ð                | 3 Widowed 4 Div  | orced If Yes, Give Year<br>or Dates:<br>cify only highest grade con | npleted) 1      |                                      | No specify:  I Occupation (Give kir      | nd of work done                      | Specify: BI                       |   |
| 72 hou   | eted             | Elementary/Secondary (0-12)  | College (1-4 or   |                 |                                      | orking life. DO NOT us                   |                                      | TOD. THIS OF BUSINES              | Soft (Castley                             |
| 5-0036 led within 7 Hygiene. lother than   | Completed        | 12   | 4   |                 | COMPUTER ]                           | NFORMATION                               | N SPEC.                              | COMPUTE                           | ER  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.                                |                  | 17. Father's Name (First, Middle,  | Last)   |                 |                                      | 18.Mother's                              | Name (First, Middle, M               | laiden Surname)                   |   |
| 2121<br>ould be fil<br>Mental<br>marked<br>c event,  | o Be             | RICHARD SMITH  19a. Informant's Name/Relations   | hin (Tyrne Print )  |                 | 10h Mailing Addros                   |  | RET QUARLE:<br>er or Rural Route Num |                                   | 7- O-d-)                                  |
| MD 2<br>od 2 shou.<br>Ilth and N<br>n 27 is n  | ۲                |  |   |                 |                                      |  |                                      |                                   |   |
| e, N<br>I and I<br>Health<br>item I  |                  | MARGARET SMITH 20a. Method of Disposition  |   |                 | ace of Disposition (Na               |  | AVE BALTII                           | MORE MARY<br>20c. Location - City | Or Town, State                            |
| nor<br>ages<br>ant of<br>nt: If  |                  |  | n 3 Removal from St   | 310             | ematory or other place<br>G MEMORIAI |  | 7/22/2006                            | DANDATICE                         | OUTN MD                                   |
| Baltimore,<br>permit. Pages I an<br>Department of Hee<br>Important: If ite   |                  | 4 Donation 5 Other Sp<br>21 Signature of Funeral Service   |   | KIIK            | 22. Name an                          | d Address of Facility                    | 07/22/2006                           |                                   |   |
| E F C E  |                  | Daloun C   | 5   |                 | 1206 V                               | . North At                               | N COMMUNITY                          | MD 21217                          | HOME P.A.                                 |
| Physician<br>/Medical  |                  | 23a Part I. Enter the disease, failure. List only one cause  |   | the death. D    | o not enter the mode                 | of dying, such as card                   | diac or respiratory arre             | st, shock, or heart               | Approximate Interval<br>Between Onset and |
| Examiner   |                  | Immediate Cause (Final disease or condition resulting in death)  | a. Gunshot wound  Due to (or as a cons                              |                 |                                      |  |                                      |                                   | Death                                     |
|  |                  | Sequentially list conditions,  | b.  | equence or).    |                                      |  |                                      |                                   |   |
|  | ner              | if any, leading to immediate cause. Enter Underlying Cause   | Due to (or as a cons  | equence of):    |                                      |  |                                      |                                   |   |
|  | Examiner         | (Disease or injury that initiated events resulting in death) Last  | c.  Due to (or as a cons  | equence of).    |                                      |  |                                      |                                   |   |
| executed<br>an and<br>al - transit   |                  |  | d   |                 |                                      |  |                                      |                                   |   |
| be exe   | dic              | UNPENDED   | AMENDED   |                 |                                      |  |                                      |                                   |   |
| Box 68760, e death certificate be ex the attending physician ed for use as the burial.   | Physician/Medica | IF FEMALE:<br>23b. Was decedent pregnant in the  | 23c. If yes, outcome 1 Live birth                                   | ne of pregna    |                                      | 3 Ectopic p                              | recnancy                             | 23d Date of deliv                 | ery<br>Day <b>Y</b> ear                   |
| x 68<br>th certi   | icia             | past 12 months?  | 4 Pregnant at   | time of deat    |                                      |  | regrancy                             | WOTE                              | Day Teal                                  |
| Bo<br>ne dear<br>the at  | hys              |  | g Unknown   |                 |                                      |  | . Log aller                          |                                   |   |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri | ρ                | Part II. Other significant condit  | tions contributing to deat  | h but not resi  | ulting in the underlyir              | ig cause given in Part                   |                                      | 2 No 3 P                          | to the cause of death?                    |
| ds,<br>equire<br>een sig<br>ould b   | Completed        |  |   |                 |                                      |  | 24a. Was a                           |                                   | autopsy findings available                |
| COF<br>lawr<br>has b   | ag m             |  |   |                 | <del></del>                          |  | autops<br>perfor                     | sy prior t<br>med? death          | o completion of cause of                  |
| Re<br>I: The<br>tificate<br>or, pag  |                  | 25. Was case referred to medica  |   |                 |                                      | 26 Place of Death (C                     | heck only one)                       | 2 No 1 🗸                          | Yes 2 No                                  |
| of Vital Records, ng Physician: The law requir offer this certificate has been sineral director, page 2 should b   | o Be             | examiner?  | Hospital:   | ent 2 🗸 E       | R/Outpatient 3                       | Othor:                                   |                                      | Residence 6 Ott                   | ner:                                      |
| n of Vit<br>ding Physic<br>After this<br>funeral dire  | Η.               | 27. Manner of Death  | 28a. Date of Inju   | iry 2           | 8b. Time of Injury                   | 28c. Injury at Work?                     |                                      | ow injury occurred                |   |
| ion<br>frendi<br>leath<br>for: /<br>the fr   | atio             | 1 Natural 5 Pend<br>2 Accident Inve  | Jul 16, 2006  | ,               | 0000 hrs                             | 1 Yes 2 🗸 N                              | Subject shot                         |                                   |   |
| Division spital or Attendivours after death  | Certification    | 3 Suicide 6 Coul   | ld not be 28e. Place of Ir  | -               | ne, farm, street, factor             | y, office building, etc.                 | 28f. Location (S<br>or Town, St      |                                   | Rural Route Number, City                  |
| Division To the Hospital or Attent within 24 hours after death To the Funeral Director:  |                  | 4 Homicide   | rmined (Specify) LD   |                 |                                      |  | 3607 Cottag                          | e Ávenue, Baltir                  |   |
| To the Hos<br>within 24 h<br>To the Fun<br>completely  | Medical          | (Check only   Certifying P   | hysician: To the best of m<br>miner:On the basis of exa             | -               |                                      |  |                                      |                                   |   |
| To the within To the comple  | Med              | 29b. Signature and title of certifie   | and manner stated   |                 |                                      | c License number                         |                                      | 29d Date signed (#                |   |
|  |                  | 70/01/11   | 12.   |                 |                                      | O.C.M.E.                                 |                                      | July 17, 2006                     |   |
| 7  |                  | 30 Name and address of person  | who completed cause of o  | leath (Item 2   | 3a)                                  |  |                                      |                                   |   |

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State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

ORIGINAL

|                            |   |                   | For<br>State<br>Registrar   | State of Mary  |                              | epartment<br>Certificate                                   |   |                                       | , ,  | iene <sub>2</sub>       | 006                                 | 22508   | )   |
|----------------------------|---|-------------------|---|--|------------------------------|--|---|---------------------------------------|--|-------------------------|-------------------------------------|---|-----|
|                            | Physici<br>/Medic   |                   | 1. Decedent's Name (First, Middle,  | Last)  |                              | رز ک   | 745   |                                       | ate of Deat<br>Month                         | Day                     | Soo &                               | 3. Time of Death 936 PM                                     |     |
| <i>&gt;</i>                | Examin Funeral Director   | er                | 4a. Facility Name (If not institution)  The Johns  5. Social Security Number  219–38–5381   | topkins Hos  | pita<br>Vrs. last birth      | Bul-   | own, or Location  Year If Under  Days Hours | ar 24 Hrs. 8                          | Pate of Birth<br>Month, Day,                 |                         | 9. Bir                              | th  |     |
|                            | ט   |                   | Usual Residence of Decedent  10a. State 10b. County   |  | c. City, Town                | or Location  |   |                                       |  |                         |                                     | 10d. Inside City Limits                                     | _   |
|                            | e Mary<br>Ba-f eh   | Director          |   | N/A  | Balt                         | imore  |   |                                       |  |                         |                                     | 1 <b>x</b> Yes 2 □ No                                       |     |
|                            | th with the 23a or 2  |                   | 10e. Street and Number<br>1527 Lester Mc  | orton Ct.  |                              | 10f. Zip 0   | 21205                                       |                                       | 1  | •                       | n of What C                         | ountry?   |     |
| 36                         | is after dea<br>it, or Items  | by Funeral        | 11. Marital Status  1 □XNever Married 2 □ Married 3 □ Widowed 4 □ Divorced  | 12. Was Decedent Ever<br>Armed Forces?<br>1 ☐ Yes 2 🗷 No<br>If Yes, Give<br>Year or Dates: | in U.S.                      | 13. Was Decede<br>If Yes, specif                           | ty Cuban, Mexic                             | an, Puerto Hicar                      | Yes or No-<br>n, etc.)                       |                         | Race - Ami<br>Black, Whi<br>pecify: | erican Indian,<br>te, etc.<br>Black                         |     |
| 21215-0036                 | ges 1 end 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel; or items 23a or 28a-f ehow or other traumatic event, ite Medical Exact | Completed         | 15. Decedent's<br>(Specify only highest<br>Elementary/Secondary (0-12)  | Education<br>grade completed)<br>College (1-4or 5+)  |                              | Decedent's Usual<br>(Give kind of work<br>life. DO NOT use | done during mo<br>retired)                  |                                       |  |                         | of Business                         |   |     |
|                            | al Hygid<br>other   | Be Co             | 10th<br>17. Father's Name (First, Middle, La  | N/A  | ıvaı                         | ley Forg   |   | ry Acade<br>her's Name (Firs          |  |                         | COOK<br>imame)                      |   | _   |
| Maryland                   | should be<br>and Mental<br>marked o   | ٥                 | Willie Sin  19a. Informant's Name/Relationship  | nms<br>(Type, Print)   | 19b.                         | Mailing Address (  | -   | Helen                                 |  | iver                    | own State                           | Zin Code)   | _   |
|                            | end 2 s<br>ealth ar<br>n 27 is  |                   | Sterling Simms  | , Sr brothe  | er 7                         | 000 Conc   | ord Rd.                                     | Pikesvi                               | lle,   | MD :                    | 21208                               |   |     |
| Baltimore,                 | Pages 1<br>nent of Ha<br>ant: if iter<br>ary or oth   |                   | 20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe   | ☐Removal from State  | cemetery                     | Disposition (Name<br>y, crematory or oth<br>rmel Cem       | ner place)                                  | 7/18/20                               |  |                         | tion - City or<br>imore             | Town, State MD  |     |
| Batt                       | permit. Page<br>Depertment of<br>Important: if<br>arry injury or<br>orce.   |                   | 21. Signature of Funeral Service Lie  | consee   |                              |  | Address of Fac                              | MARCH                                 |  |                         | HOME-E                              |   | Ī   |
|                            | Physician<br>/Medical   |                   | 23a. Part1. Enter the disease, or co<br>shock, or heart lailure. List or<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)         | a. Introl  | erebr                        | ot enter the mode  | ol dying, such a                            |                                       | Balto.                                       | est,                    | 212                                 | Approximate Interval Between Onset and Death                |     |
| 60,                        | physicien end must set the burial-transit   | ai Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last | b. Due to (or as a co  | tos.                         | on):<br>On<br>of):   |   |                                       |  |                         |                                     | 30 years  |     |
| P.O. Box 68760,            | law requires that the death certificate<br>as been signed by the attending physi<br>2 should be detached for use as the i   | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No   | d.  23c. If yes, outcome of p  1 Live birth 2 4 Pregnant at time                           | Fetal death                  | 3 □Ectopic pre<br>5 □ Other (spe                           |   |                                       |  | 230                     | d. Date of de<br>Month              | livery<br>Day Year  | 370 |
|                            | w requires that<br>been signed<br>should be del   | þ                 | Part II. Other significant condition  | s contributing to death but no   | ot resulting in              | the underlying ca  | use given in Par                            | RI.                                   |  | pacco use<br>es 2□t     |                                     | o the cause of death?                                       |     |
| Division of Vital Records, | The<br>ete h<br>page  | Completed         |   |  |                              |  |   |                                       | 24a. Was a<br>autops<br>perforr<br>I 🗆 Yes 2 | iy                      | prior to death?                     | utopsy findings available<br>completion of cause of<br>2 No |     |
| fVit                       | Physiciar<br>this certif<br>at directo  | To Be             | 25. Was case referred to medical examiner?  1 Yes 2 No  | Hospital: 1 Inpatient  | 2 ER/Out                     | patient 3 DOA  | Other                                       | ce of Death <i>Ch</i><br>Nursing Home |  |                         | ☐Other (Spe                         | ocify)  |     |
| sion o                     | ling l  | Certification:    | 27. Manner of Death  1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no  | 28a. Date of Injury<br>(Month, Day Ye  | 28b. T<br>ar) Ir             | ime of 28<br>njury M                                       | ic. Injury at<br>Work?<br>1 Yes 2 [         | □ио                                   | Describe ho                                  |                         |                                     |   |     |
| Σ                          | ital or At<br>rs efter o<br>el Direct<br>led in by  | Certifi           | 4 Homicide determin   |  | At home, far<br>Specify)     | rm, street, lactory,                                       | office                                      | 28f. L                                | ocation (St<br>City or Town                  | reet and N<br>n, State) | Number or R                         | ural Route Number,  |     |
|                            | To the Hospital or Attend within 24 hours effer death To the Funerel Director: completely filled in by the it   | Medical           | 29a. Certifier (Check only one) Certifying Medical Ex   | Physician: To the best of m<br>caminer: On the basis of exa<br>and manner stated.          | y knowledge<br>amination and | , death conumed a<br>Vor investigation, i                  | t the time date of the my opinion, do       | and plans, and death occurred at      | the time, d                                  | ate and pl              | id his mer a<br>ace, and du         | s tated.<br>o to the cause(s)                               |     |
|                            | with  | Σ                 | 29b. Signature and title of certifier   | 4 8  |                              | 0  | License number                              | <b>0</b> 7                            | _  | T 1                     |                                     | th, Day, Year)  |     |
| 1                          | y   |                   | 30. Name and address of person w  | no completed cause of death  | (Item 23a) (                 | Type, Print)   |   | 0 -                                   |  | ייון                    | 13,                                 | 2006  | _   |
|                            | Sta   |                   | 31. Date filed (Month, Day, Year)  JUL 1 9  | 2006 32. registrar's   | Signature                    | Correll s  | Three                                       | 1 B                                   | eltin  | hore                    | MD                                  | 21247   |     |
|                            | Regist  | ar                | OOL T 9   | LUUU JURELAR   | 1 1                          | Marie  |   |                                       |  |                         |                                     |   |     |

State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 2006 July 15, 4:50 A M Cynthia Sasser /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Rossville Rossville Baltimore Co. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 😡 F 51 212-74-9370 Vrc Director April 25,1955 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ir than "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 21 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 904 Foxcroft Lane 21221 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian e filed within 72 hours after of Hygiene. other than "natural", or iter Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify: à White 3℃Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Information Operator Communications 17. Father's Name (First, Middle, Last) permit. Peges 1 end 2 should be filk Department of Health and Mental Hy important: if Item 27 is marked oth any injury or other traumatic evant ange. 18. Mother's Name (First, Middle, Maiden Sumame) Be Donald Shaw Darlene Voyzey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mandy Leuwen (Daughter) 15 Pickens Ct. Baltimore, Maryland 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 7/18/2006 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cem. Baltimore, Maryland 21. Signal re of Juneal Service Ligensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ate hes been signed by the etter page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 2 N funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1No Medical Certification: To this 3□ DOA After t 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred s after decrei Ate 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D55306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1 9 2006

Philadelphia Rd Suite 200 Batta Md

06-04984 Please Type or Print in Black Indelible Ink UNK UNK State of Maryland / Department of Health and Mental Hygiene Autoria Sields. For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Medical Examiner 2041 hrs July 12, 2006 Antonio G. Shields 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore 5. Social Security Number 6 Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Director Hours 216-98-6493 02 68 XXM 2 F 38 13 Yrs Country) MD Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits s 23a or 28a-f show e notified at once. or 28a-f show 1 XYes 2 Baltimore MD NA hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 1113 U.S.A.

14 Race - American Indian, Black, Sargeant Street Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nope Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White etc. 1 Yes 9 Black Widowed Divorced Give Yea Yes 2X No specify Specify item 27 is marked other than "natural", traumatic event, the Medical Examiner þ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 l 21215-0036 Floor Tech. llth grade na Self Employed nt of Health and Mental Hygiene
t: If item 27 is marked other th
other traumatic event, the Med 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Lizzie Shields Robert Lee Dunham 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lizzie Shields-Mother 1107 North Dukeland St. Balto, M**đ** 21216 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important: injury or oth Department 7/21/06 King Memorial Park Randallstown, Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, 21215 Md Physician Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Between Onset and /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical attending physician or use as the burial UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death 2 Month Dav Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✔ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical Hospital or Attending Physician: 26 Place of Death (Check only one) Be Hospital: 1 ✔ Inpatient 2 Other<sub>4</sub> ER/Outpatient 3 Nursing Home 5 Residence 6 1 Yes After 27. Manner of Death 28a. Date of Injury Jul 12, 2006 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot by police Natural 2007 hrs 5 Pending Yes 2 V No Director: 2 Accident Investigation 28e. Place of tnjury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Rear of 1104 S. Carey , Baltimore, MD determined (Specify) Vacant Building 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Wedical To the one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c License number 29d Date signed (Month, Day, Year) O.C.M.E. July 13, 2006

Registrar
DHMH 17 Rev 1/2001

**OCME 2006** 

State

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

9 2006

Assistant Medical Examiner

32 Registrar's Signatur

Caller

Laron Locke MD.

oth, Day, Year,

31. Date filed (Month

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician GERALD SEWARD JULY 16, 2006 3:10 P<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 133 FLEMING DRIVE TURNER STATION BALTIMORE 5. Social Security Number 6. Sex 1 X M 2 ☐ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Months Days Hours Min 215-46-9682 58 Yrs. Director 09-27-1947 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at Director 1X Yes 2 No MD BALTIMORE TURNER STATION 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 133 FLEMING DRIVE 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whife, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 À 1 ☐ Yes 2 No 3 ☐ Widowed 4 Divorced Specify: BLACK Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SAND BLASTER SHIPYARD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H Be MARGARET MCDONALD WILLIAM SEWARD ၉ 19a. Informant's Name/Relationship (Type, Print)
DAWN SEWARD/SISTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is 1941 BARRY ROAD, BALTIMORE, MD 21222 20a. Method of Disposition

X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if its
any injury or ot 4 ☐ Donation 5 ☐ Other (Specify) **ARBUTUS** 07/20/06 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC asses u. 1701 LAURENS STREET, BALTO., MD 21217 P. L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Inferval Betw Inferval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Squamous CELL CARLINDINA MONTHS /Medical Due to (or as a consequence of): Examiner SHAMINET NUTRITION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physicien and s the burial-transit Due to (or as a consequence di) Physician/Medical ettending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnanf af fime of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 ₽1No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No his 2 ER/Outpatienf 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; To the Hospitel or Attending I within 24 hours effer death. To the Funaral Director: After 1 Natural 5 Pending М investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗀 Suicide Place of fnjury - Af home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Thunders MD 528132 7/18/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 N. CHAMES BALTIMONE MO 21204 6569 #200 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 9 2006 Registrar

Box 68760,

Division of Vital Records, P.O.

|                            |  |                  | 1 - For State Registrar   | State of Marylar  | nd / Depa<br><i>Cei</i>  | artmen<br><i>rtificat</i>              | t of Hea<br>e of De    | alth and M<br>eath                                     | lental H                           | ygiene<br>Reg. No     |                  | 06                        | 225/2   |
|----------------------------|--|------------------|---|---|--------------------------|--|------------------------|--|------------------------------------|-----------------------|------------------|---------------------------|---|
| E                          | Physici  | an               | Decedent's Name (First, Middle, Last)     Barbara Karen   | Turner  |                          |  |                        |  | 2. Date of I<br>Month<br>July      | Da                    | <br>006          | Year                      | 3. Time of Death 1:15 A. M                        |
| - delay                    | /Medic<br>Examir   |                  | 4a. Facility Name (If not institution, give s<br>6007 Parkway Drive   | street and number)  |                          | 4b. City,                              |                        | cation of Death  | buly                               | 40                    | . County         |                           | orges   |
| ŀ                          | Funeral<br>Director  |                  | 213-00-9403   | 7. Age (In yrs.   |                          | If Under<br>Months                     |                        | Under 24 Hrs.<br>Hours Min.                            | 8. Date of E<br>(Month, I<br>April | Birth<br>Day, Year    | )                | 9. Birthp                 | place (State or Foreign<br>ntry)<br>ington, D.C   |
|                            | Maryland<br>f ehow   | or               | Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Ge   |   | ity, Town or Lo<br>aurel | cation                                 |                        |  |                                    |                       |                  |                           | 0d. Inside City Limits                            |
|                            | with the Page or 28a-  | Funeral Director | 10e. Street and Number<br>6007 Parkway Drive  | e   |                          | 10f. Zip                               | Code<br>20707          |  |                                    |                       | itizen of W      |                           | -   |
| 336                        | be filed within 72 hours after death with the Maryland lat Hygiane. d other than "naturel", or items 23s or 28s-f show event. I'm Medical Examinar must be notified at   | by Funera        | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates: |                          | Was Deced<br>f Yes, spec<br>1  Yes     | cify Cuban, N          | nic Origin? (Sp<br>Mexican, Puerto<br>Specify:         | ecify Yes or I<br>Rican, etc.)     | No-                   |                  | k, White,                 |   |
| 21215-0036                 | within 72 hou<br>ane.<br>than "nature<br>he Medical E  | Completed        | 15. Decedent's Edul (Specify only highest grade Elementary/Secondary (0-12)   | cation  | (Give                    | dent's Usua<br>kind of wo<br>DO NOT us |                        | n<br>ng most of work                                   | ing                                |                       | Kind of Bu       |                           |   |
| 77                         | al Hygi<br>I other   | To Be Co         | 17. Father's Name (First, Middle, Last) Harvey Earle Brow   | n   | 00.20                    |  | 18.                    | . Mother's Name  |                                    | le, Maide             |                  |                           |   |
| , Mary                     | 7 1 2  |                  | 19a. Informant's Name/Relationship (Ty) John A. Turner/ Hu  |   |                          |  |                        | Number or Rura<br>ive, La                              |                                    |                       |                  | State, Zip                | Code)   |
| Baltimore,                 | permit. Peges 1 end<br>Depertment of Heelt<br>Important: If Item 2:<br>eny injury or other 1<br>once.  |                  | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)  | temoval from State We   |                          | nde1                                   | ther place)<br>Cremat  | ory Jul  | _                                  | Ode                   | enton            | , Ma                      | own, State<br>ryland                              |
|                            | Depertition of the point of the |                  | 21 Prinature of Fundal Service Ucense 23a. Part T. Enter the disease, or compli   | Globe   |                          |  | P.O. E                 | Box Wash   | nington                            | n, D.                 | c. 2             | Ser<br>0037               | vices, Inc.                                       |
| 8760,                      | Cate be executed hysician and physician and physician and the burial-transit the burial-transit  | dical Examiner   | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d. |   |                          |  |                        |  |                                    |                       |                  |                           | Interval Between Onset and Death                  |
| .O. Box 6                  | death certifi<br>a attending<br>id for use as  | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown   | 3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of a                  | al death 3               | Ectopic pr<br>Other (sp                |                        |  |                                    |                       | 23d. Date<br>Mor |                           | ory<br>Day Year                                   |
| <u> </u>                   | The law requires thet the tte bas been signed by the baga 2 should be deteched.  | ρ                | Part II. Other significant conditions con   | ntributing to death but not re  | sulting in the u         | nderlying c                            | ause given ir          | n Part I.  |                                    | tobacco               |                  |                           | ne cause of death?                                |
| Division of Vital Records, |  | Completed        |   |   |                          |  |                        |  | pe<br>1 ☐ Yes                      | topsy<br>formed?<br>2 | P                | Vere autorior to coreath? | psy findings available impletion of cause of 2 No |
| Ĭ                          | ysicien:<br>is certific<br>director.   | o Be             | 25. Was case referred to medical examiner?  1 Yes 2 No  | lospital: 1 Inpatient 2   | ] ER/Outpatien           | * 3 \ O                                | Other                  | <ol> <li>Place of Death</li> <li>Nursing Ho</li> </ol> | - 1                                |                       | 6 (10th          | /00004                    |   |
| ion of                     | Ing Ph   |                  | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation   | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury   | _                                      | 8c. Injury at<br>Work? |  | 28d. Describ                       |                       |                  |                           | ,   |
| Divis                      | spital or Attendious effer death<br>eral Director: A   | Certification:   | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Injury - At h<br>building, etc. (Speci  | nome, farm, str          | eet, factory                           | v, office              |  |                                    | (Street a.            |                  | er or Rura                | l Route Number.                                   |
|                            | To the Hospital or within 24 hours effective to the Funeral Dir. completely filled in I  | Medical          |   | ner: On the bast of my kn<br>ner: On the basis of examinand manner stated.                      |                          |  |                        |  |                                    |                       |                  |                           |   |
|                            | To the Hos<br>within 24 h<br>To the Fur<br>completely  | Me               | 29b. Signature and title of certifier   | 1/1   |                          | - 1                                    | . License nu           |  |                                    |                       | -                |                           | Day, Year)  |
| )<br>                      | 1  |                  | 30. Name and address of person who co   | lally in  | D 2201 (Time             | Print                                  | 0311                   | 90   | drum                               | JU                    | 14               | 17                        | 2006  |
| ·                          | <i>y</i>   |                  | J. GARRET   | 17 NEIIIU,  | M. D.                    | ennt)                                  | 0/2                    | 1EY,   | MD                                 | 208                   | 32               | ,                         |   |
| Ī                          | Sta<br>Regist  |                  | 31. Date filed (Month, Day, Year)  JUL 1 9 2  | 32. Registrar's Sign  | ature                    | bort                                   | الع                    |  |                                    |                       |                  |                           |   |

|                            |  |                | For<br>State<br>Registrar   | State of M  | laryland /                                       | Depa / Depa                           | irtment<br>tificate                          | of He             | ealth a<br>Death                     | and M                      |                                 | iene 2                       | 006                                | 22  | 513                |
|----------------------------|--|----------------|---|---|--|---------------------------------------|--|-------------------|--------------------------------------|----------------------------|---------------------------------|------------------------------|------------------------------------|---|--------------------|
|                            | Physicia   | an             | 1. Decedent's Name (First, Middle, L<br>Jack Terrill  | ast)  |  |                                       |  |                   | -                                    |                            | 2. Date of Dea<br>Month         | Day                          | Year<br>Olo                        | 3. Time of D                              | eath<br>M          |
| ł                          | /Medic<br>Examin   |                | 4a. Facility Name (If not institution, gi   | ve street and number  | 30 01  |                                       | 4b. City, To                                 | own, or           | Location o                           | of Death                   |                                 | 4c. Count                    | y of Death                         | 1   |                    |
|                            | Funeral  |                | 5. Social Security Number 6.  |   | 'HMPL<br>ge (In yrs. last                        | birthday)                             | If Under 1                                   | Year<br>Days      | If Under                             | AC 24 Hrs. Min.            | 8. Date of Birth                |                              | 9. Birthp                          | lade (State or I                          | Foreign<br>Ink     |
|                            | Director   |                | 500-38-6975 Usual Residence of Decedent   | 1 M 2□F   | 66   | Yrs.                                  | WICHTERS                                     | Days              | riours                               |                            | June 8,                         | 1940                         |                                    |   | IIIK               |
|                            | aryland<br>ahow  | 7              | 10a. State 10b. County MD Allegar   | 137   | 10c. City, T                                     | own or Lo                             | cation                                       |                   |                                      |                            |                                 |                              | 1                                  | 0d. Inside City                           |                    |
|                            | or 28a-f   | Director       | 10e. Street and Number  |   | 1 10   | TVAIC                                 | 10f. Zip C                                   | ode               |                                      |                            | 1                               | 0g. Citizen of               | What Cour                          |   | Λ                  |
|                            | eth wil  |                | 1135 Braddock Ro  | <del></del>   |  |                                       |  | 2150              |                                      |                            |                                 | US                           |                                    |   |                    |
| 36                         | rrs after de<br>It', or Item<br>Kerdiner n   | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | 12. Was Deceden<br>Armed Forces<br>1 XYes 2 If Yes, Give<br>Year or Dates | ?<br>]No   |                                       | Vas Deceder<br>f Yes, specify<br>I ☐ Yes 2¶  |                   | spanic Ori<br>n, Mexicar<br>Specify: | gin? (Spe<br>n, Puerto I   | crfy Yes or No-<br>Rican, etc.) | Bla                          | ce-Americ<br>ck, White.<br>fy: whi | etc.                                      |                    |
| 215-0036                   | be lied within 72 hours after deeth with the Maryland<br>Hygiene.<br>do chtar than "natural", or itema 23a or 28a-f ahow<br>avant, the Modicel Examinar must be rediffed at  | npleted        | 15. Decedent's (Specify only highest g  | rade completed)  College (1-4or   |  | (Give                                 | lent's Usual (<br>kind of work<br>OO NOT use | done di           | uring mos                            | t of workii                | unk unk                         | 16b. Kind of E               | Business/In                        | dustry                                    | unk                |
| nd<br>2                    | be filed<br>Ital Hygi<br>of other<br>avant, I  | To Be Col      | unk<br>17. Father's Name (First, Middle, Las  | unk<br>()   |  |                                       | un   | k                 |                                      |                            | (First, Middle,                 |                              | me)                                |   |                    |
| ary                        | 2 should<br>and Men<br>is marke<br>aumatic   | 1              | 19a. Informant's Name/Relationship  | (Туре, Print)   |  | 19b. Mailin                           | g Address (S                                 | Street a          | nd Numbe                             | er or Rura                 | l Route Numbe                   | r, City or Town              | , State, Zip                       | Code)                                     |                    |
| ď.                         | s 1 end<br>of Health<br>item 27<br>other tr  |                | Claire Berlender  20a. Method of Disposition  1 Burial 2 Cremation 3  4 \( \D)Donation 5 Other (Spec  | ☐Removal from State   | 20b. Plac  | e of Dispo                            | Braddo<br>sition (Name<br>natory or othe     | of                |                                      |                            | berland,                        | MD 2<br>20c. Location        | 1502<br>- City or To               | own, State                                |                    |
| Balti                      | permit. Page<br>Depertment of<br>important: If<br>any injury or<br>socs.   |                | 21. Signature of Funeral Service Lic<br>Anthony D   |   | ant  |                                       | Name and<br>tate A                           |                   | •                                    |                            | 1 655 W                         | . Balti                      | more                               | Street                                    |                    |
|                            | Physician Medical Examiner with principle and physician site physic | dical Examiner | 23a. Part1. Enter the disease, or construction of the control of the cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last | a   | s a consequen                                    | 2 + E<br>nce of):<br>u en<br>nce of): |  | 256               | 12A3                                 |                            | r respiratory arr               | est,                         |                                    | Approximate Interval Between Onset and De | een<br>eath        |
| P.O. Box 68                | ath certific<br>ittending p<br>or use as   | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   |   | e of pregnancy<br>2  Fetal de<br>at time of deat | ath 3                                 | Ectopic preg                                 |                   |                                      |                            |                                 |                              | ate of delive                      | ery<br>Day Ye                             | ear                |
| rds, P                     | w requires thet the de<br>been signed by the a<br>should be deteched t   | ρ              | Part II. Other significant conditions   | contributing to death   | but not resultir                                 | ng in the ur                          | nderlying cau                                | ise give          | n in Part I                          |                            | 23e. Did to                     | /                            |                                    | ne cause of decorably 4 🗆 Un              |                    |
| Division of Vital Records, | : The law recete hes became page 2 sho   | Completed      |   |   |  |                                       |  |                   |                                      |                            | 24a. Was a autops perfor        | med?                         | prior to co<br>death?              | psy findings av<br>mpletion of cau        | vailable<br>use ol |
| Zita<br>Zita               | ysicien: The is certificate his director, page   | Be             | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No   | Hospital: 1 ☐ Inpa  | tiont 2050                                       | 2/Outsetun                            | it 3□ DOA                                    | Othe              |                                      |                            | (Check only or                  |                              | (0                                 |   |                    |
| ion of                     | iing Ph<br>h.<br>After th<br>funeral   | atlon: To      | 27. Manner of Death  1 DNatural 2 Accident  5 Pending investigat  | 28a. Date of In<br>(Month, D  |  | Bb. Time of<br>Injury                 |  | c. Injury<br>Work | 4 🗀 140                              |                            | 28d. Describe h                 | ence 6 □Ot<br>ow injury occu |                                    | y)<br>                                    |                    |
| Divis                      | Itei or Atturs efter de rai Directo  | Certification: | 3 ☐ Suicide 6 ☐ Could not determine   | d 286. Place of I   | njury - At home<br>etc. <i>(Specify)</i>         | e, farm, str                          | eet, factory,                                | office            |                                      | •                          | 28f. Location (S<br>City or Tow |                              | ber or Rura                        | l Route Numb                              | er,                |
|                            | To the Hospitei or Attending Ph<br>within 24 hours eiter death.<br>To the Funeral Director: After th<br>completely filled in by the funeral  | Medical        | (Check only 2 Medical Ex  | Physicien: To the bes<br>aminer: On the basis<br>and manner:              | of examination                                   | edge, death<br>n and/or in            | vestigation, in                              | n my op           | inion, dea                           | nd place, a<br>ith occurre | ed at the time, o               | late and place               | , and due to                       | the cause(s)                              |                    |
| )                          | To Too   | -              | 29b. Signature and title of certifier   |   | V V  |                                       | 290  | T                 | number                               |                            |                                 | 29d. Date sign               |                                    | -   | ,                  |
| 7                          |  |                | 30. Name and address of person wh   | - C.I.  | Y /  | 3a) (Type,                            | Print)                                       |                   | 007                                  | W 1                        | 5 2150                          | OR.                          | Geor                               | ge Relle                                  | grino              |
|                            | Sta<br>Regist  |                | 21 Date filed (Month Day Year)  | 32 Regis  | strar's Signatur                                 | 9                                     | and .  | inn               | 0                                    | 1 10                       | 0130                            |                              |                                    |   |                    |

State of Maryland / Department of Health and Mental Hygiene 2 () () 22514 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** VIRGINIA MCCURDY WOLZ 6:48 AM July 18 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Bethesda Montgomery 7823 English Way Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 ☐ M 2 🔀 F Yrs. 90 July 3, 1916 Pennsylvania 219-14-0058 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral', or items 23a or 28e-f ehow Examiner must be notified at 1 ☐ Yes 2 ▼No **Funeral Director** Montgomery Bethesda MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or items 23a eny injury or other treumatic event, If a Medical Examinationals. 7823 English Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12th Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Irene Krepps Harry B. McCurdy 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7823 English Way, Bethesda, MD Virginia R.W. Weber/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/25/2006 Crownsville, MD MD Veterans Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee ) M01103 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock to heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final herosclero Physician cara eans disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and Y The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 pronths? Month Year 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No sease certificete 1 Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director. D 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manger of Death Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23a) (Ty 8 Va 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 9 2006 Registrar

|                     |  |                  | For 1 State  | State of Maryland / Dep   | partment of Health and ertificate of Death                                   | -  | C000 CC010   |
|---------------------|--|------------------|--|---|--|--|--|
|                     |  |                  | Registrar  1. Decedent's Name (First, Middle, La.                                  |   | Fillicate of Death   | Reg. I                                     | No. 3. Time of Death   |
| Ŋ.                  | Physicia   |                  | 11.0.111=  | =115  |  | July 1-1                                   | Year Vear  |
|                     | /Medic<br>Examin   |                  | 4a. Facility Name (If not institution, give  | street and number)  | 4b. City, Town, or Location of Dea   |  | c. County of Death   |
|                     |  |                  | Morthwest  | HOSOITA!  | 1 40 11 7 7 7 7 1 1  | WN   | Jaltimore  |
|                     | Funeral<br>Director  |                  | 5. Social Security Number 6. S   | ex 7. Age (In yrs. last birthda)  Yrs.                              | Months Days Hours Min  |  | 9. Birthplace (State or Foreign                                      |
|                     | ס  |                  | Usual Residence of Decedent  | 10.00   |  | 0 110011                                   | 10001 11   |
|                     | ehow   | 'n               | 10a. State 10b. County   | 10c. City, Town or  | Location ()  |  | 10d. Inside City Limits 1 Tyes 2 No                                  |
|                     | the N  | rect             | 10e. Street and Number   | Swy   | 10f. Zip Code  | 10a. G                                     | Citizen of What Country?   |
|                     | h with   | ai Di            | 7403 Mars-   | ton Rd.   | 21207  |  | INSA   |
|                     | tems :   | Funeral Director | 11. Marital Status   | Armed Forces?   | Was Decedent of Hispanic Origin? (S     If Yes, specify Cuban, Mexican, Puer | Specify Yes or No-<br>to Rican, etc.)      | 14. Race - American Indian,<br>Black, White, etc.                    |
| 36                  | irs efte   | by F             | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced                             | 1 □Yes 2 No If Yes, Give Year or Dates:                             | 1 ☐ Yes 2 No Specify:  |  | Specify: Black   |
| 9                   | 72 hou<br>natura   | ted              | 15. Decedent's Ed<br>(Specify only highest gra                                     | tucation 16a Dec  | cedent's Usual Occupation  | 16b.                                       | Kind of Business/Industry  |
| 2                   | vithin 7   | Completed        | Elementary/Secondary (0-12)  | dollege (1-4or 5+)  | ve kind of work done during most of wo<br>DO NOT use retired                 | 10 -                                       | Rachica  |
| р<br>О              | filed v<br>Hygie<br>ther t   |                  | 17. Father's Name (First_Mittelle, Last)   | YF ACC  | 18. Mother's Na  | me (First, Middle, Maid                    | en Sumame)   |
| Maryland 21215-0036 | permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Heelth and Mental Hygiene. Importent: If Item 27 ie marked other than "natural", or items 23s or 28e-f show any injury or other traumatic event, Tra Medical Examinar risat he nutified at once. | To Be            | David Slau   | ahter   | Hat  | re III                                     | t  |
| lar                 | 2 should<br>and Men<br>le marke<br>sumatic   |                  | 19a. Informant's Name/Relationship   | e, Primi  | iling Address (Street and Number - A   | ral Route Number, City                     |  |
|                     | 1 end<br>Heelth<br>am 27<br>thar tr  |                  | 20a. Method of Disposition   | ey laughter +4  | position (Name of enhatory or other place)                                   | Date COVAN                                 | Location - Gty or Town, State  |
| Baltimore,          | Pages<br>nent of h<br>int: If Its  |                  | 1 Curial 2 Cremation 3 C 4 Donation 5 Other (Specif                                | Tremovar nom State  | rematory or other place)   | 21/2006 A                                  | a L. L. m  |
| altir               | permit. Page<br>Depertment of<br>Importent: If<br>eny injury or<br>once.   |                  | 21. Signature of Funer II Service Liper  |   | 28 Marne and Ax ress of Placilit   | 2000 Fis                                   | neval Services   |
| œ<br>—              | Depermine Impo   |                  | Vauxon C   | ! Treese !  | 8728 E. berty Ro   | 1. Randul                                  | Stain, MD 21132  |
|                     |  |                  |  | plications that ceused the death. Do not e one cause on each line.  | inter the mode of dying, such as cardia                                      | c of respiratory arrest,                   | Approximate Interval Between Onset and Death                         |
|                     | Physician /Medical   |                  | Immediate Cause (Final disease or condition resulting in death)                    | a. MTRACRAN   | VIAL HEMOXRH   | FIE  |  |
|                     | Examiner   |                  |  | Due to (or as a consequence of):                                    | PILEPTICUS.  |  |  |
| Щ                   | P #  | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a consequence of):                                    |  |  |  |
|                     | and and II-trans   | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last            | c. Due to (or as a consequence of):                                 | v. He c  | u-   |  |
| 8760,               | ficate be executed<br>physiclen and<br>is the burial-transit   | dical E          |  | a M2Helma   | US ONCLIE  |  |  |
| 9                   | rtificat<br>ng phy<br>r as th  | Medi             | IF FEMALE:   |   |  |  |  |
| Вох                 | ath ce   | lan/             | 23b. Was decedent pregnant in the past 12 months?                                  |   | Ectopic pregnancy  |  | 23d. Date of delivery  Month Day Year                                |
| o                   | The law requires that the death certifi<br>tie has been signed by the ettending to<br>bage 2 should be deteched for use as   | Physician/Me     | 1 Yes 2 No<br>9 Unknown  | 4□Pregnant at time of death 5<br>9□ Unknown                         | □ Other (specify)  |  | ,  |
| <b>a</b>            | res that<br>igned b  | by Ph            | Part II. Other significant conditions of   | contributing to death but not resulting in the                      | underlying cause given in Part I.  | 23e. Did tobacci                           | o use contribute to the cause of death?                              |
| ord                 | w require<br>been sig<br>should b  | ted t            |  |   |  | 1 🗆 Yes                                    | 2 No 3 Probably 4 Unknown  |
| Records,            | a law r<br>has be  | Completed        |  |   | ·  | 24a. Was an autopsy                        | 24b. Were autopsy findings available prior to completion of cause of |
| <u>a</u>            |  |                  | 05.11  |   |  | performed?                                 |  |
| Ē                   |  | To Be            | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No                          | Hospital: 1 Inpatient 2 ☐ ER/Outpati                                | Other  | ath (Check only one)  Home 5 Residence     | 6 □Other (Specify)   |
| n of                | ding Phys<br>n.<br>After this<br>funeral di  |                  | 27. Manner of Death  | 28a. Date of Injury (Month, Day Year) Injury                        | of 28c. Injury at  | 28d. Describe how in                       |  |
| Siol                | tendir<br>leath.<br>lor: Al<br>the fu  | catic            | 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b               |   | M 1 ☐ Yes 2 ☐ No   |  |  |
| Division of Vital   | To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer  | Certification:   | 4 Homicide determined  | 28e. Place of Injury - At home, farm, s<br>building, etc. (Specify) | street, factory, office  | 28t. Location (Street<br>City or Town, Sta | and Number or Rural Route Number,<br>ate)                            |
|                     | psplte<br>hours<br>unerel<br>y fillec  |                  | 29a. Certifier 1 Certifying Ph   | ysician: To the best of my knowledge, de                            | ath occurred at the time, date and place                                     | e, and due to the cause                    | (s) and manner as stated.  |
|                     | the H<br>hin 24<br>the Fi  | Medical          | one)   | niner: On the basis of examination and/or and manner stated.        |  |  |  |
|                     | S T N S  | -                | 29b. Signature and title of certifier  | mella mo  | 29c. License number  | /,, /                                      | Date signed (Month, Day, Year)                                       |
| À                   | 1  |                  | 30. Name and address of person who   | completed cause of death (Item 23a) (Type                           |  | MEHTA                                      | 11111111   |
| 0                   |  |                  | MURTHUEST HUP  | THE CENTER "  | RAMONKSTULY  | mo 211                                     | 33 .   |
|                     | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)  JUL 1 9 20                                      | 32. Registrar's Signature   | racks  |  | -  |
|                     | riegisti   | uı               | 00L T 0 E0   | January De Maria  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 1 - For State Registrar Certificate of Death 's Name (Firsa Middle, Last) 2. Date of Death 3. Time of Death **Physician** oun 6-200 6 /Medical Name (If not institution, give 4b. City Town, or Vocation of Death afland number) 4c. County of Death Examiner ture Care timore
If Under 24 Hr. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1□M 25 F 2 Months Days Hours Min Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Be Completed by Funeral Director i more 10f. Zip Code 21 21 6 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 KNo Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT useretifed) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ath Father's Name (First Middle, Last) ouna or Rural Route Number, City or Town, State, Zip Code) 1 MD 2/216 20a. Method of Disposition Date 20c. Location - City or Town, State Cremation 3 Removal from State Burial 4 □ Donayon 5 □ Other (Specify) 21. Signature of Funeral Service Licens MD 2/133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart ail are. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cohrows Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnapt 23d. Date of delivery 3 Ectopic pregnancy in the past 12 morms.

1 Yes 2 No Day 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

Physician /Medical **Examiner** 

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Wadral Examiner intellibet at once.

Baltimore, Maryland 21215-0036

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Physician/Medical Examiner Be Completed by

ician and burial-transit director, ٥ Medical Certification: ithin 24 hours after death.

the Funeral Director: A

pmpletely filled in by the fu

autopsy performed 2 🗆 No 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

25. Was case referred to medical examiner' 2 No 1 Tyes 27. Manne of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 Could not be determined

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other:

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 9

30. Name and address of Men

29d. Date signed (Month, Day, Year)

127569 who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

06-04993 Please Type or Print in Black Indelible Ink Sherrell Walker State of Maryland / Department of Health and Mental Hygiene 225 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 12, 2006 **Medical Examiner** 1853 hrs Sherrel1 Henry Walker 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital **Baltimore** 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign South Months Days Hours Director 1\_XM 2 F 215-26-5781 74 April 16,1932 Carolina Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show notified at once. Yes 2 X No Pages 1 and 2 should be filed within 72 hours after death with the Maryland Maryland Anne Arundel Severn Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' United States 21144 1966 Arwell Court Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 X Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1X Yes Give Year 1952-1954 Divorced Yes 2 No specify Black ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th Equipment Operator Garbage Removal 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hi Important; If item 27 is marked o injury or other traumatic event, If Be Bridwell Mildred Joyce Greenfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara E. Walker/wife 1966 Arwell Court Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)
Maryland Veterans 1 X Burial 2 Cremation 3 Removal from State 7/21/2006 Donation 5 Other Specify: Crownsville, Maryland Cemeterv 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.

Odenton. Maryland 21113 Signature of Funeral Service Licensee Amodeo 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea **Physician** failure. List only one cause on each line Between Onset and /Medical Hemoperitoneum due to ruptured abdominal aortic aneurysm Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of)

Due to (or as a consequence of)

Examiner Physician/Medical Completed by Be Certification:

Hospital or Attending Physician: The law requires that the death certificate be executed

this

within 24 hours a

To the Funeral I

completely filled

Medical

State

Registrar

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions,

if any, leading to immediate

| cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of):   | -                   |                            |                                       |
|---|--|---------------------|----------------------------|---------------------------------------|
| XXUNPENDED  | AMENDED item#23a,27,permE,g85/,//27/06 TT  |                     |                            |                                       |
| IF FEMALE:  | 23c. If yes, outcome of pregnancy  | 2                   | 23d. Date of delivery      |                                       |
| 23b Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknow                           | 1 Live birth 2 Fetal death 3 Ectopic pregnance 4 Pregnant at time of 5 Other (Specify) 9 Unknown | у                   | Month Day                  | Year                                  |
| Part II. Other significant conditions   | contributing to death but not resulting in the underlying cause given in Part I.                 | 23e. Did tobacc     | o use contribute to the ca | use of death?                         |
|   |  | 1 Yes 2             | No 3 Probably              | 4 🗹 Unknown                           |
|   |  | 24a. Was an autopsy | 24b. Were autopsy to       | indings available<br>tion of cause of |
|   |  | performed*          |                            |                                       |

1 ✓ Yes 2 N 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 / Inpatient Other<sub>4</sub> ER/Outpatient 3 Nursing Home 5 Residence 6 1 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c, Injury at Work? 28d. Describe how injury occurred 1 X Natural Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (tem 23a)

July 14, 2006

Death

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year) 9 2906 Registrar's Signature

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician Clarence Rickie Wilson Year July 17. 2006 6:10 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore CL-2

Il Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 5,1947 N/A Johns Hopkins Bayview Medical Ctr. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1XM 2□ F West Virginia Yrs Director 58 212-46-6532 Usual Residence of Decedent 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28e-1 ehow the Medical Examiner must be notified at 1 Yes ZXNo Directo Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a 21222 Unites States 1602 Pumphrey Street death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "naturel", or ite Affined Folces. 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: Vietnam 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Store Convenience Clerk Year Coll. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Juanita Holsteen Wilson ဂ Clarence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dundalk, Maryland Mrs. Helen E. Wilson (Wife) 1602 Pumphrey Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny Injury or once. 7/21/2006 Baltimore, Maryland ◆ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Sign tu ol Funeral Service Licensee 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and DA Immediate Cause (Final disease or condition resulting in death) na/ignent Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant the atter 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the at id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been sig 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate 20 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 XER/Outpatient 3 DOA this within 24 hours after death.
To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 12 Certifying Physician: To the hest of my knowledge death oncurred at the time data and plate and fluste the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier o the 29b. Signature and title of 29d. Date signed (Month, Day, Year) driftia 29c. License number use of death, (Item 23a) (Type, Print) 9/03 Franklin Sq. Dr. St. 2200 Dalto, mb 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

|   |                 | . 101  | ndelible Ink. Ensure A<br>partment of Health and I<br>ertificate of Death                           | Mental Hygie                                      | ne <sub>2006</sub>                                | 22519   |
|---|-----------------|--|---|---|---|---|
| Physicia<br>/Medic  |                 | 1. Decedent's Name (First, Middle, Last) Mary Helen Wojci  | echowska  | 2. Date of Death<br>Month<br>July 16              | Day Year  | 3. Time of Death 6:04 P M                               |
| Examine   | _               | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death  |   | 4c. County of Death                               |   |
|   |                 | Franklin Wood Nursing Home   | Rossville  Rossville  If Under 1 Year   If Under 24 Hrs.  | La Barra (Birth                                   | Baltimo   |   |
| Funeral<br>Director   | ř               | 5. Social Security Number  6. Sex 1 M 3 F 7. Age (In yrs. last birthd 218-05-9046  Usual Residence of Decedent   | Months Days Hours Min   | 8. Date of Birth (Month, Day, Ye June 1, 1        | 9 Birthol<br>Coun<br>918 Mar                      | ace (State or Foreign<br>try)<br>yland                  |
| a-f show  | ctor            | 10a. State 10b. County 10c. City, Town of Baltimore  |   | osedale   | 10  | 0d. Inside City Limits 1 ☐ Yes 2₹3€No                   |
| th with the   | ai Director     | 10e. Street and Number<br>7907 Dalerose Ave.   | 10f. Zip Code 21237   |   | Citizen of What Coun                              | •   |
| lrs a   | by Funeral      | 11. Marital Status  XXNever Married 2  | Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert     □ Yes 2 ☑ No Specify: | pecify Yes or No-<br>o Rican, etc.)               | 14. Race - Americ<br>Black, White, of<br>Specify: |   |
| in 72   | Completed       | (Specify only highest grade completed) (G  | ocedent's Usual Occupation<br>ive kind of work done during most of wor<br>e. DO NOT use retired)    | rking 161   | . Kind of Business/Inc                            | lustry  |
| filed w<br>Hygier<br>other th   |                 | 8 Years  | Seamstress  |   | London Fo   | Co.   |
| be filed<br>ntal Hyg<br>od other  | Be              | 17. Father's Name (First, Middle, Last)  |   | ne (First, Middle, Mai                            | ,   |   |
| should be filed with<br>nd Mental Hyglene.<br>marked other thar<br>imatic event, the  | ٩               | Frank Wojciechowska  19a. Informant's Name/Relationship (Type, Print)  19b. M  | ailing Address (Street and Number or Ru   | Cieslewicz  |   | Corto   |
| d 2 st<br>th and<br>7 is r  |                 |  | 6 Wren Way Newark   |   | _   | Code)   |
| 1 and<br>Health<br>Iam 27   | L.V             |  | sposition (Name of crematory or other place)  |   | . Location - City or To                           | wn, State   |
| Pages<br>nent of<br>int: if it  |                 | 1 Ed Dullar 2 Dicientation 3 Dinamoval nom State   | 1   |   | altimore,   |   |
| permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic expires.                             |                 | 21. Signature of Funeral Service Licensee  | 22. Name and Address of Facility Duda-Ruck Funera 7922 Wise Ave.                                    | 1 Home of   | Dundalk, I  |   |
| Physician<br>/Medical   |                 | 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a  |   |   |   | Approximate Interval Between Onset and Death            |
| bur bur   | Icai Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):   | attery dixa   | lse   | 4   | Ogas  |
| The law requires that the death certificate is are has been signed by the attending physipage 2 should be detached for use as the t                               | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown  | 3 □Ectopic pregnancy<br>5 □ Other (specify)   |   | 23d. Date of delive<br>Month                      | ry<br>Day Year  |
| w requires that the doben signed by the should be detached  | þ               | Part II. Other significant conditions contributing to death but not resulting in the Rechal carcinoma  | e underlying cause given in Part I.   |   | co use contribute to the                          | . /   |
| The law reate has bee   | Completed       |  |   | 24a. Was an autopsy performed                     | prior to cor<br>d? death?                         | osy findings available<br>npletion of cause of<br>28 No |
| ysicien: The lis certificate ha   | Bec             | 25. Was case referred to medical examiner?   | 26. Place of Dea  | ath (Check only one)                              |   |   |
| hysic<br>his ce<br>Il dire  | 10              | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa  |   | lome 5 ☐ Residenc                                 | e 6 □Other (Specify                               | )   |
| ding Ph<br>h.<br>After th<br>funeral  | o               | 27. Manner of Death 1 S\atural 5 □ Pending 28a. Date of Injury (Month, Day Year) Injury Inju  | ry Work?  | 28d. Describe how                                 | injury occurred                                   |   |
| To the Hospital or Attending Physicien: within 24 hours after death. To the Fundeel Director: After this certifical completely filled in by the funeral director, | Certification   | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)   | M 1 ☐ Yes 2 ☐ No<br>, street, factory, office   | 28f. Location (Stree<br>City or Town, S           | ot and Number or Rura<br>State)                   | l Route Number,   |
| To the Hospital or Attenwithin 24 hours after deat<br>To the Funeral Director:<br>completely filled in by the   | edica C         | 29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, control of the basis of examination and/control one)   | eath occurred at the time, date and place<br>or investigation, in my opinion, death occu            | a, and due to the caus<br>arred at the time, date | e(s) and manner as st<br>and place, and due to    | ated.<br>the cause(s)                                   |
| To th<br>within<br>To th<br>compl   | Me              | 29b. Signature and Ht. of certifier  | 29c. License number  \$\int 6173/\$   | 29d.  | Date signed (Month, )                             | Day, Year)  |
| 27  |                 | 30. Name and address of person who completed cause of death (Item 23a) (Ty   |   | rare Dri  | Je 310,   | Banilz;   |
| Sta<br>Registr  |                 | 30. Name and address of person who completed cause of death (Item 23a) (Ty According to the Control of the Cont | refe  |   |   | 7   |

DHMH 17 Rev 1/2001

Stanley Keith Woodley

#### Please Type or Print in Black Indelible Ink

| ,                 |   |
|-------------------|---|
| State of Maryland | Department of Health and Mental Hygiene |

|   |          | For State   |   | Certific                                | cate of                      | Death   |                               |                                    |                         | g No                                  | 00                             | c 00E0   |
|---|----------|---|---|---|------------------------------|---|-------------------------------|------------------------------------|-------------------------|---------------------------------------|--------------------------------|--|
| Physician/<br>Medical Examiner  | 1.       | Decedent's Name (First, Middle,Las<br>STANLEY KEIT  |   |   |                              |   | Ju                            | ate of Deatl<br>onth<br>Ily 9, 200 | Day Ye.<br>)6           |                                       | 3-Time of Death C-<br>1350 hrs |  |
|   | 4a       | Facility Name (if not institution, giv<br>Southern Maryland Hospit  |   |   | 41                           | Clinton   | ·                             |                                    |                         | 4c. County<br>Prince (                | George's                       |  |
| Funeral<br>Director   |          | Social Security Number 6. Security Number 17 5054   | 7. Age (  | In yrs. last bi                         | rthday)<br>Yrs.              | If Under 1 Year Months Days                                       | If Under<br>Hours             | Min. S                             | Sept 2                  | 26, 1961                              | /) 9. 8irth<br>Foreign<br>Cour | <sup>pl</sup> Carolina<br><sup>ntry)</sup> North                                   |
| nd<br>show any<br>ice,  | 10<br>M. | ual Residence of Decedent a State 10b. County aryland Prince (  |   | 0c. City, Tow                           | n or Locatio                 |   |                               |                                    |                         | · · · · · · · · · · · · · · · · · · · |                                | 10d Inside City Limits 1 Yes 2 XXNo  |
| th the Maryland 23a or 28a-f show notified at once. al Director   | 10       | e. Street and Number<br>5170- A Sij   | jan Court   |   |                              | 10f. Zip Code 207   | 62                            |                                    | 10                      | United                                |                                | *  |
| after death wi<br>all, or items<br>iner must be   | 11       | Marital Status  Never Married 2 XX Married  Widowed 4 Divorced  5. Decedent's Education (Specify of   | TXX Yes 2 1<br>If Yes, Give Year<br>or Dates:                           | No                                      | If Ye                        | Decedent of Hisp s, specify Cuban,  Yes 2 XXNo s Usual Occupation | Mexican, F                    | Puerto Rica                        | n, etc.)                |                                       | te, etc<br>B1a                 | an Indian, 8lack,  ack   |
| 5-0036 de within 72 hours get within 72 hours tygiene. other than "natur he Medical Exam Completed I  | -        | Elementary/Secondary (0-12)   | College (1-4 or 5+  | ·)                                      | during mo                    | st of working life. I   |                               |                                    |                         | Milit                                 |                                |  |
| ID 21215-0036 should be filed within 7/ and Mental Hygiene. 7/ is marked other than matic event, the Medical To Be Comple                                   |          | . Father's Name (First, Middle, Last<br>Reginald W  | oodley, JR.   |   | 0. 14.7                      |   | Jear                          | nnette                             | e Wood                  | -                                     |                                | 7-0-1-   |
| nore, MD 21 sages I and 2 should nt of Health and Me tt: If item 27 is ma other traumatic er  | L        | on Informant's Name/Relationship (1) Monica W. Woodle  Da Method of Disposition   |   | 19                                      | 5170 A                       | Address (Street Sijan C   | ourt,                         | , AAFE                             | 3, MD                   | 20762                                 |                                |  |
| Baltimore, MD 2121 permit Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event, To Be | 1 4      | X Xurial 2 Cremation 3  Donation 5 Other Specify  Signature of Funeral Service Jon  | gsee  | Linco                                   | oln Me                       | er place)<br>moria <u>l</u> C<br>ame and Address<br>exandria      | emet of Facility              | ery<br>Lee H                       | Tunera                  | Roper.                                | Nor<br>, 663                   | th Carolina  |
| Physician<br>/Medical<br>Examiner   | li o     | Ba. Part I. Enter the disease, or com failure. List only one cause on e nmediate Cause (Final disease a r condition resulting in death)  equentially list conditions, any, leading to immediate ause Enter Underlying Cause |   | ne death. Do<br>mboembol<br>quence of). | not enter th                 | e mode of dying, s  | such as car                   | rdiac or res                       | piratory arre           | est, shock, or he                     |                                | Approximate Interval<br>Between Onset and<br>Death                                 |
| 760, from the executed physician and the burial - transit   |          | Disease or injury that initiated vents resulting in death) Last  UNPENDED   | Due to (or as a consec  |   |                              |   |                               |                                    |                         |                                       |                                |  |
| 76<br>icat<br>ph<br>the   | - 2      | FEMALE: b Was decedent pregnant in the past 12 months?  Yes 2 No 9 Unknow   | 23c. If yes, outcom  1 Live birth 4 Pregnant at t                       |   | 2 Fet                        | al death 3 [<br>er (Specify)                                      | Ectopic                       | pregnancy                          |                         | 23d Date of Month                     | ,                              | ay Year  |
|   | 2        | art II. Other significant conditions  | contributing to death   | but not result                          | ting in the u                | nderlying cause gi  | ven in Par                    | rt I.                              |                         | s 2 No 3                              | Proba                          | he cause of death?  ably 4  Unknown  opsy findings available ompletion of cause of |
| Records,  In: The law requires tificate has been signor, page 2 should be   |          | 5 Was case referred to medical  |   |   |                              | 26 Place  | of Death (                    | Check only                         | perfo<br>1 <b>V</b> Yes | rmed?                                 | death?                         |  |
| of Vi<br>ling Physi<br>After this<br>funeral dir  |          | examiner?  1  Yes 2 No  7. Manner of Death  1  Natural 5 Pending 2 Accident Investige   | 28a Date of Injur<br>(Month, Day,Ye                                     | 2 <b>V</b> ER                           | /Outpatient<br>b. Time of I  | njury 28c. Injur  | Other <sub>4</sub> y at Work? |                                    |                         | Residence 6<br>how injury occu        | Other:                         |  |
| Division o  To the Hospital or Attending within 24 hours affer death To the Funeral Director: Afte completely filled in by the fune                         |          | Suicide 6 Could no determin   | at be ed (Specify)  |   |                              | t, factory, office bi   |                               |                                    | or Town, S              | State)                                |                                | al Route Number, City  |
| To the Howithin 24 P. To the Funcompletely  |          | 2 Medical Examin  | cian: To the best of my<br>er:On the basis of exan<br>and manner stated | knowledge,<br>nination and/o            | death occur<br>or investigat | red at the time, da<br>ion. in my opinion,<br>29c. License        | death occ                     | ce, and due                        | to the cause time, date | and place, and                        | due to the                     | ecause(s)  th, Day, Year)  |
|   |          | 19b. Signature and title of certifier  10. Name and address of person who   | completed cause of de   | ath (Item 23                            | )<br>a)                      | O.C.M   |                               |                                    |                         | July 10, 2                            |                                | 5), . 50//   |
| Stat  |          | Theodore King MD. As  | ssistant Medical E  | xaminer                                 | 111 Pe                       | nn Street, Bal  | timore,                       | MD 2120                            | )1                      |                                       |                                |  |
| Registra<br>DHMH 17 Rev 1/200   | ar       | JUL 1 9 20  | 06 Sugar  | <u> </u>                                | ORIGINA                      |   |                               |                                    |                         |                                       |                                |  |

|                                |   | -                | For<br>State<br>Registrar   | State of Maryland   |                        | artment of H                               |                                     | Mental Hy                             | giene<br>Reg. No.             | 06 2                                | 2521                 |
|--------------------------------|---|------------------|---|---|------------------------|--|-------------------------------------|---------------------------------------|-------------------------------|-------------------------------------|----------------------|
|                                |   |                  | Decedent's Name (First, Middle, Last)   |   |                        |  |                                     | 2. Date of De                         | ath                           |                                     | ime of Death         |
|                                | Physicia<br>/Medic  |                  | Mary Frances Walsh  |   |                        |  |                                     | July 1                                | Day<br>14, 2006               | Year 2:4                            | .5 а <sup>м</sup>    |
|                                | Examin  |                  | 4a. Facility Name (If not institution, give st  | reet and number)  |                        | 4b. City, Town, or                         | Location of Dea                     | ith                                   | 4c. County                    |                                     |                      |
|                                |   |                  | 932 Whispering Ridg   |   |                        | Bel A                                      |                                     |                                       |                               | ford                                |                      |
|                                | Funeral   |                  | 5. Social Security Number 6. Sex  | 7. Age (In yrs. la  | st birthday)<br>Yrs.   | If Under 1 Year<br>Months Days             | If Under 24 Hr<br>Hours Mir         | . (Month, Da                          | ay, Year)                     | Country)                            | State or Foreign     |
|                                | Director  | -                | 097-16-4223 Usual Residence of Decedent   | x 83  |                        |  |                                     | Aug.                                  | 3, 1922                       | New Yor                             | k                    |
|                                | yland   |                  | 10a. State 10b. County  | 10c. City   | , Town or Lo           | cation                                     |                                     |                                       |                               | 10d. Ins                            | ide City Limits      |
|                                | a-fsl   | ctor             | Md. Harford   |   | Bel Ai                 | .r   |                                     |                                       |                               | 10                                  | Yes 2 No             |
|                                | or 28   | Funeral Director | 10e. Street and Number  |   |                        | 10f. Zip Code                              |                                     |                                       | 10g. Citizen of V             | What Country?                       |                      |
|                                | ath w   | rai              | 932 Whispering Ridg   |   |                        | 2101                                       |                                     |                                       | U.S.A                         | <del></del>                         |                      |
|                                | er de<br>Items  | nue              |   | 2. Was Decedent Ever in U.S<br>Armed Forces?              | 3. 13.                 | Was Decedent of Hi<br>f Yes, specify Cubai | spanic Origin? (<br>n, Mexican, Pue | Specify Yes or No<br>rto Rican, etc.) | b- 14. Rac<br>Blac            | e - American Ind<br>ck, White, etc. | ian,                 |
| 36                             | Ir, or  | by               | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates:          |                        | 1 ☐ Yes 2 ☑ No                             | Specify:                            |                                       | Specify                       | white                               | <b>!</b>             |
| 9                              | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23a or 28a-f show<br>its Madical Examither must be notified at  | Completed by     | 15. Decedent's Educa  | ation   | 16a. Deced             | ient's Usual Occupa                        | ition                               |                                       | 16b. Kind of Bu               | usiness/Industry                    |                      |
| 215                            | e.<br>an "n   | pie              | (Specify only highest grade<br>Elementary/Secondary (0-12)  | College (1-4or 5+)  | lite.                  | kind of work done d<br>DO NOT use retired, | fu <i>ring most of w</i> i          | orking                                |                               |                                     |                      |
| 21                             | ed wi   | Sol              |   | 4   | homen                  | aker                                       |                                     |                                       | own h                         |                                     |                      |
| pu                             | be fit<br>ntal H<br>od oth  | Be               | 17. Father's Name (First, Middle, Last)   |   |                        |  |                                     | ame (First, Middle                    | , Maiden Suman                | 18)                                 |                      |
| 7                              | d Mer<br>narke  | P                | Michael P. Tully  19a. Informant's Name/Relationship (Type)   | - Dring)  | 405 14-16              | ng Address (Street a                       |                                     | Markey                                | - 0° - T                      | 0 . 7 0                             |                      |
| <b>∑</b>                       | d 2 s<br>th an<br>th an<br>traus  |                  | Lisa McHugh/daughte   | •   |                        | 1 Othello                                  |                                     |                                       |                               |                                     |                      |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be political at 2009. |                  | 20a. Method of Disposition  | 20b. Pl   | ace of Dispo           | sition (Name of                            | 1                                   | Date                                  |                               | City or Town, St                    | ate                  |
| 9E                             | Pages<br>ent of<br>nt: If I   |                  | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)  | moval from State  | -                      | natory`or other place<br>.tent Cem.        | · I                                 | 0/2006                                | Rankey                        | ille, N.                            | V                    |
| altii                          | mit. I<br>partm<br>portal<br>/ inju   |                  | 21. Signature of Funeral Service Licenses   |   |                        | . Name and Addres                          | s of Facility                       | 11.5                                  |                               |                                     | 1.                   |
| Ď                              | Depa<br>Impo<br>any in  | ın<br>al         | Stefance  | Kunok   | 201                    | Schimunek<br>610 W. Ma                     |                                     |                                       |                               |                                     | h                    |
|                                | A   |                  | 23a. Part1. Enter the disse, or complice shock, or heart failure. List only one                             | ations that caused the death.                             | Do not ent             | er the mode of dying                       | g, such as cardia                   | ac or respiratory a                   | rrest,                        | Appro                               | ximate<br>al Between |
|                                | Physician   |                  | Immediate Cause (Final disease or condition   | C   | ence                   | liens                                      |                                     |                                       |                               | Onse                                | and Death            |
|                                | /Medical<br>Examiner  |                  | resulting in death)   | Due to (or as a consequ                                   | ence of):              |  | )                                   |                                       |                               | 0                                   |                      |
|                                |   | -                | Sequentially list conditions, b.  | Due to (or as a consequ                                   | ence of).              |  |                                     |                                       |                               |                                     |                      |
| .18.                           | nsit  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Dab to (or as a consequ                                   | arica 01).             |  |                                     |                                       |                               |                                     |                      |
| Ms                             | sician and<br>burial-transit  | Еха              | that initiated events c. resulting in death) Last   | Due to (or as a consequ                                   | ence of):              |  |                                     |                                       |                               |                                     |                      |
| 8760                           | cate be exphysician   | dical            | d.  |   |                        |  |                                     |                                       |                               |                                     |                      |
| 9                              |   | Med              | IF FEMALE:  |   |                        |  |                                     |                                       | 1.                            |                                     |                      |
| . Box                          | leath certific<br>attending p<br>I for use as   | an/l             | 23b. Was decedent pregnant in the past 12, menths?  | c. If yes, outcome of pregnar<br>1 ☐ Live birth 2 ☐ Fetal | death 3                | Ectopic pregnancy                          |                                     |                                       | 23d. Dai                      | te of delivery                      | Year                 |
| 0.                             | that the death cer<br>ed by the attendir<br>detached for use  | Physician/Me     | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4□Pregnant at time of de<br>9□Unknown                     | ath 5□                 | Other (specify)                            |                                     |                                       | 1010                          | nth Day                             | 1 Bal                |
| 9.                             | that the  | Ph               | Part II. Other significant conditions cont  | ributing to death but not resu                            | lting in the u         | nderlying cause give                       | en in Part I                        | 23e. Did t                            | obacco use cont               | ribute to the caus                  | se of death?         |
| ds,                            | The law requires that the death certifi<br>ate has been signed by the attending t<br>oage 2 should be detached for use as   | d by             | 3   |   | and a the s            | idonying oddoo giro                        |                                     |                                       |                               | 3 Probably                          |                      |
| 202                            | w requ  | ete              |   |   | _                      |  |                                     | 24a. Was                              | an 24h )                      | Were autopsy fine                   | dinge available      |
| Re                             | ician: The lav<br>certificate has<br>ector, page 2  | Completed        |   |   |                        |  |                                     | auto                                  | psy<br>prmed?                 | prior to completion death?          | n of cause of        |
| <u>ta</u>                      |   | 0                | 25. Was case referred to medical  |   |                        |  | 26. Place of De                     | 1 ☐ Yes<br>eath (Check only o         |                               | Yes 2 N                             | 0                    |
| <u> </u>                       | s s   | To B             | examiner?   | spital: 1   Inpatient 2   E                               | R/Outpatier            | t 3 DOA Othe                               | a de                                | Home 5 Resi                           |                               | er (Specify)                        |                      |
| 0 0                            | ding Pt   |                  | 27. Manner of Death 1 X latural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Year)                  | 28b. Time of<br>Injury | 28c. Injury<br>Work                        | at                                  | 28d. Describe                         | how injury occurr             | 'ed                                 |                      |
| <u>S</u>                       | Attending<br>or death.<br>ector: After<br>by the fune   | cati             | 2 Accident investigation  |   |                        |  | /es 2□No                            |                                       |                               |                                     |                      |
| Division of Vital Records, P.O | or Attence<br>after death<br>Director:<br>in by the   | Certification:   | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At hor building, etc. (Specify,    | me, farm, str          | eet, factory, office                       |                                     | 28f. Location (<br>City or To         | Street and Numb<br>wn, State) | er or Aural Route                   | Number,              |
|                                | spital<br>ours a<br>neral I   |                  | 29a. Certifier 1/2 Certifying Physi   | cian: To the best of my know                              | vledge deat            | occurred at the tim                        | a date and place                    | e and due to the                      | cause(s) and ma               | inner as stated                     |                      |
|                                | To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral   | Medical          | (Check only 2 Medical Examine one)  | er: On the basis of examinati and manner stated.          | on and/or in           | vestigation, in my op                      | inion, death occ                    | curred at the time,                   | date and place,               | and due to the ca                   | use(s)               |
|                                | To the within 2 To the complet  | Me               | 29b. Signature and title of certifier   | $\circ$   |                        | 29c. License                               |                                     |                                       | 29d. Date signed              | d (Month, Day, Y                    | ear)                 |
| T                              |   |                  | My M  | ソ   |                        | DI   | 8487                                |                                       | 7/11                          | 106                                 |                      |
|                                | 24  |                  | 30. Name and address of person who con  | . ) -   |                        | Print)                                     | 7                                   | ALA                                   | MD-                           | 21011                               |                      |
|                                | Sta   | te               | 31. Date filed (Month, Day, Year)   | 32. Registrar's Signat                                    | WOO.                   | D GOTT                                     | N) 1360                             | AIR,                                  | (") 0                         | 7                                   |                      |
|                                | Registr   |                  | JUL 1 9 20  | 600   | the so                 | hours                                      |                                     | •                                     |                               | /                                   |                      |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10:40 A.M. Ruth Wattenschaidt 06 /Medical 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner CAMPUS BrAddock umber and der 1 Year I If Under 24 Hrs. AlleGAni UMUS-8. Date of Birth (Month, Day, Year) Sept 22, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1□M 2♥F Sept 1920 213-36-3731 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits work r than "natural", or items 23a or 28a-f ahov the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Allegany Frostburg MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21532 1 Kaylor Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "are injury or other traument." Elementary/Secondary (0-12) College (1-4or 5+) 0 office clerk Blue Cross/Blue Shield 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Sidney Leake Maude Margretta Winter ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6510 Ridenour Way East #2 Sykesville, MD 21784 Shirley Ritgert/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ∑Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility
State Anatomy Board
Baltimore, MD 21201 Pleasant 655 W. Baltimore Street Teasar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 RUSEPSIS **Physician** TWODAY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) by the a 1 ☐ Yes 2 ☑ No 9 Unknown s been signed by should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete hes birector, page 2 s autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Watural 5 Pending investigation within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 126907 Hello 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BISHOP WASH ROAD, Comberland, MD 21503 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 9 2006

DHMH 17 Rev 1/2001

|                                |   |                  |   | State of Ma  | ryland / I       |                     | tment of F   |                             |                        |  | ienę 🗍 [         | 06                    | 22523                                      |
|--------------------------------|---|------------------|---|--|------------------|---------------------|--|-----------------------------|------------------------|--|------------------|-----------------------|--|
|                                |   |                  | 1. Decedent's Name (First, Middle, Last)  |  |                  |                     |  |                             | 499                    | 2. Date of Deat                        | h                | Ves                   | 3. Time of Death                           |
|                                | Physicia  | _                |   | Shirley M  | lae Abe          |                     |  |                             |                        | Month<br>July                          | Day<br>03, 2006  | Year                  | 11:01 P.M.                                 |
|                                | /Medic<br>Examin  | _                | 4a. Facility Name (If not institution, give s.  |  |                  |                     |  | 4b. City, To                | wn, or Lo              | cation of Death                        | 4c. County       | of Death              |  |
|                                |   |                  | Egle 1  | Nursing Hom  | ie               |                     |  |                             | onacor                 |  |                  |                       | gany                                       |
|                                | Funeral   |                  | 5. Social Security Number 6. Sex  | 7. Age   | (In yrs. last bi |                     | If Under 1 Year<br>Months Days                           | If Under<br>Hours           | 24 Hrs.<br>Min.        | (Month, Day,                           | Year)            | 9. Birth              | place (State or Foreign<br>ntry)           |
|                                | Director  |                  | 216-05-5013 Usual Residence of Decedent   | т 2 дз 1   | 86               | Yrs.                |  |                             |                        | May 19,                                | 1920             |                       | Maryland                                   |
|                                | and =   | ŀ                | 10a. State 10b. County  |  | 10c. City, Tov   | wn or Loca          | ation  |                             |                        |  |                  |                       | 10d. Inside City Limits                    |
|                                | Mary<br>Fed sh  | ţ                | Maryland Allega   | ny   |                  |                     | ŀ  | Lonacor                     | ning                   |  |                  |                       | 1 Yes 2 No                                 |
|                                | h the   | ie               | 10e. Street and Number  | -  |                  |                     | 10f. Zip Code  |                             |                        | 1                                      | 0g. Citizen of V | Vhat Cou              | ntry?                                      |
|                                | should be filed within 72 hours after death with the Maryland and Mentle Hygiene. Ind Mentle Hygiene. Inakted other than "natural" or items 23a or 28a-f show unatic event, the Medical Examination and the indiffed at   | Funeral Director | 57 Jackso   | n Street   |                  |                     |  | 21539                       |                        |  |                  |                       | of America                                 |
|                                | r dea   | ne               | Tr. Maria States  | <ol><li>Was Decedent E<br/>Armed Forces?</li></ol> |                  | 13. W               | as Decedent of H<br>Yes, specify Cub                     | lispanic Ori<br>an, Mexicar | gin? (Spe<br>n, Puerto | ecify Yes or No-<br>Rican, etc.)       |                  | e - Ameri<br>k, White | can Indian,<br>, etc.                      |
| 20                             | s afte<br>, or it   | by Fi            | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 🛣 N<br>If Yes, Give<br>Year or Dates:    | 0                | 1                   | □Yes 21 No   | Specify:                    |                        |  | Specify          | <i>'</i> :            | White                                      |
| 3                              | tural   | ed               | 15. Decedent's Educ   | ation  | 16a              | a. Decede           | nt's Usual Occup   | pation                      |                        |  | 16b. Kind of Bu  | usiness/Ir            |  |
| 212                            | 72 nin 72<br>n " na<br>Wedik  | plet             | (Specify only highest grade<br>Elementary/Secondary (0-12)  | completed) College (1-4or 5-                       | +)               | (Give ki<br>life. D | nt's Usual Occup<br>ind of work done<br>O NOT use retire | during mos<br>d)            | t of work              | ing                                    |                  |                       |  |
| 2                              | d with<br>giene<br>er tha   | Completed        | 9   | 0  | .,               |                     | Owne   | er / Ope                    |                        |  |                  |                       | Store                                      |
| ng                             | al Hy<br>3 othe   | Be (             | 17. Father's Name (First, Middle, Last)   |  |                  |                     |  | 18. Mothe                   | er's Name              | e (First, Middle, I                    |                  |                       |  |
| yla                            | ould to Ment  | ဥ                |   | nard Warnicl                                       |                  |                     | (0)  |                             |                        |  | na Turnbul       | -                     | - O- d-1                                   |
| Mar                            | 12sh<br>hand<br>rism<br>traum   |                  | 19a. Informant's Name/Relationship (Type<br>Robert McBee - N  |  | 19               | b. Mailing          |  |                             |                        | a <i>l Route Number</i><br>I, Swanton, |                  |                       |  |
| e,                             | 1 and<br>Healt<br>9m 27   |                  | 20a. Method of Disposition  | 1cpnew   | 20b. Place       | of Disposi          | ition (Name of   |                             | reduc                  |  | 20c. Location -  |                       |  |
| <u>o</u>                       | ages<br>ant of<br>t: If it<br>y or o  |                  | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Laurel Hill Cemetery                            |  |                  |                     |  |                             |                        | y 08, 2006                             | Moscov           | v Mill                | s, Maryland                                |
| Baltimore, Maryland 21215-0020 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is merked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be indiffed at once. | - 0              | 21. Signature of Funeral Service License  | е  |                  |                     |  |                             |                        | Kenzie Fur                             |                  |                       |  |
| ñ                              | Deparenti<br>Importanti<br>any it   |                  | I Am E. Maken   | -  |                  | ł                   |  |                             |                        | t, Lonaconi                            |                  |                       |  |
|                                |   |                  | 23a. Per 1 Enter the disease, or complete shock, or heart failure. List only on   | cations that caused                                | the death. Do    | not enter           |  |                             |                        |  |                  |                       | Approximate<br>Interval Between            |
|                                | Physician   | 18               | shook, of heart failure. List only on   |  |                  |                     |  |                             |                        |  |                  |                       | Onset and Death                            |
|                                | /Medical<br>Examiner  |                  | Immediate Cause (Final disease or condition   | ac   | nt               | My                  | o contro   | e i                         | mes                    | writi cr                               |                  |                       | pours                                      |
|                                | Examine   | <u>.</u>         | resulting in death)   |  | Due to (or as a  | a consequ           | ence of):  | 0                           |                        | witi a                                 |                  |                       | years                                      |
|                                | ted   | Examiner         | <b>₽</b> b  |  | orons            | my                  | Britan   | 16                          | sea                    | مهلا ر                                 |                  | <u> </u>              | gens                                       |
| ~                              | cate be executed<br>physician and<br>the burial-transit   | Exal             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | '  | Due to (or as a  | a consequ           | rence or):   |                             |                        |  |                  |                       |  |
| 8760,                          | ysicia  | dical            | Cause (Disease or injury that initiated events  |  | Due to (or as a  | consequ             | ence of):  |                             |                        |  |                  |                       |  |
| 9                              | ng ph<br>as th  |                  | resulting in death) Last  |  |                  |                     |  |                             |                        |  |                  |                       |  |
| Box                            | law requires that the death certific<br>as been signed by the attending p<br>a 2 should be detached for use as  | Physician/M      | <b>4</b> d  |  |                  |                     |  |                             |                        |  |                  |                       |  |
|                                | e dea<br>the at<br>hed fo   | /sic             | Part II. Other significant conditions con   |  |                  |                     | -0.00  |                             | l.                     |  |                  |                       | to the cause of death?                     |
| P.0.                           | that the  | Ph               | Coloni<br>Deep venous   | 18m  | De               | men                 | t18  |                             |                        | 1 □ Y                                  | es 2□ No         | 3 □ Pro               | Unknown                                    |
| Division of Vital Records,     | sign<br>d be  | d by             |   |  |                  |                     | . /  |                             | -                      | 24a. Waş a                             |                  |                       | Vere autopsy findings<br>vailable prior to |
| Ö                              | w requ  | Completed        | Coloni  | c car  | nceR             | - 1                 | to 5 To  | ry o                        | 8                      | perfor                                 | med?             | C                     | ompletion of cause<br>f death?             |
| Re                             | The lay<br>ate has<br>page 2  | шo               | Deed 1/2 as and   | Harmit   | 6055             | 1                   |  |                             |                        | 1 🗆 Y                                  | es 2             | 1                     | ☐ Yes 2☐ No                                |
| ta                             | an: Tificat<br>tificat<br>tor, pi   | Be               | 25. Was case referred to medical  | 2  |                  | U                   | د ( ۲  | 26. Plac                    | e of Deat              | h (Check only or                       | 10)              |                       |  |
| <b>₹</b>                       | Physician:<br>r this certific<br>ral director,  | To B             | examiner?<br>1 ☐ Yes 2 🗷 No   | ospital: 1 🗆 Inpatie                               | nt 2 ER/C        | Outpatient          | 3□ DOA Ot  | her: 4                      | ursing Ho              | ome 5 🗆 Resid                          | ence 6 □Oth      | er (Spec              | ify)                                       |
| 0                              | ng Ph<br>fter th<br>ineral  |                  | 27. Manner of Death  1 ☐ Natural 5 ☐ Pending  | 28a. Date of Injur<br>(Month, Day                  |                  | . Time of<br>Injury | 28c. Inju  |                             |                        | 28d. Describe h                        | ow injury occur  | red                   |  |
| sio                            | Attending or death. ector: Atterby the fune   | cati             | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be   | On Bloom of India                                  | At home          | form atro           |  | Yes 2                       |                        | 28f Location /S                        | treet and Numi   | er or Ru              | ral Route Number,                          |
| $\leq$                         | or Att<br>after d<br>Direct<br>in by  | Certification:   | 4 Homicide determined   | 28e. Place of Inju-<br>building, etc               | c. (Specify)     | rarm, stre          | et, ractory, office                                      |                             |                        | City or Tow                            | n, State)        | 07 710                | an riodic removi,                          |
| _                              | spital<br>ours<br>ours<br>beral I   |                  | 29a. Certifier Certifying Phys  | ician: To the best of                              | of my knowledg   | ge, death           | occurred at the t  | ime, date ar                | nd place,              | and due to the c                       | ause(s) and ma   | anner as              | stated.                                    |
|                                | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2  | edical           | (Check only 2 Medical Examination)  | ner: On the basis of<br>and manner sta             | examination a    | and/or inve         | estigation, in my  | opinion, dea                | ath occur              | red at the time, d                     | late and place,  | and due               | to the cause(s)                            |
|                                | To th<br>Withir<br>To th<br>comp  | ž                | 29b. Signature and title of certifier   |  |                  |                     | 29c. Licen   |                             |                        |  | 29d. Date signe  |                       |  |
|                                |   |                  | 1 Ju  | ~/   |                  |                     | Di   | 212                         | 44                     |  | 7/3              | 5/0                   | 6  |
| •                              | 1.  |                  | 30. Name and address of person who co   | mpleted cause of d                                 | eath (Item 23a   | a) (Type, F         | Print)   |                             | /                      | /                                      | ,                | 1                     | 11000                                      |
|                                | 4   |                  | Jesus H. TAN  | M.D. 4   | Brond            | WAY                 | STAGET   | FA                          | este                   | urg, M.                                | ArylANC          | K.                    | 21552                                      |

Registrar

DHMH 16 Rev 6/95

|                            |   | 1               | For<br>State<br>Registrar   | State of Maryland  |                             | rtment of H<br>tificate of L                                     |                                | d Mental H                           | ygiene<br>Reg. No  | ZUUb                               | 22524  |
|----------------------------|---|-----------------|---|--|-----------------------------|--|--------------------------------|--------------------------------------|--------------------|------------------------------------|--|
|                            | 40  |                 | Decedent's Name (First, Middle, Last)   |  |                             |  |                                | 2. Date of I                         | Death<br>Day       | v Year                             | 3. Time of Death                                   |
|                            | Physicia<br>/Medic  |                 | ZILLIAN   | AUSTIN   |                             |  |                                | JUNE                                 | 27                 | 2006                               | 17:01 M  |
| 1                          | Examin  | _               | 4a. Facility Name (If not institution, give st  | reet and number)   |                             | 4b. City, Town, or   | Location of D                  | eath                                 | 4c.                | . County of Death                  |  |
|                            |   |                 | 3233 WALTERS LAN  |  |                             | FORESTV  |                                | Ura la a                             |                    | RINCE GEO                          |  |
|                            | Funeral   |                 | 5. Social Security Number 6. Sex  | 7. Age (In yrs. la:  | st birthday)  <br>Yrs.      | If Under 1 Year<br>Months Days                                   | Hours N                        | din. (Month,                         | Day, Year)         |                                    | place (State or Foreign                            |
|                            | Director  | -               | Usual Residence of Decedent   | <sup>M 2</sup> 49  | 113.                        |  |                                | DEC.                                 | 8 19               | JO WASH                            | INGTON.DC  |
|                            | land<br>ow  |                 | 10a. State 10b. County  | 10c. City,   | Town or Loc                 | cation   |                                |                                      |                    |                                    | 10d. Inside City Limits                            |
|                            | Mary<br>eah   | ţō              | MD PRINCE GE  | ORGE'S FOR   | ESTVI                       | LLE  |                                |                                      |                    |                                    | 1X Yes 2 □ No                                      |
| :                          | r 28a   | Director        | 10e. Street and Number  |  |                             | 10f. Zip Code  |                                |                                      | -                  | tizen of What Coul                 | ntry?  |
| :                          | 13a o   | 0               | 3233 WALTERS LANE   | # 104  |                             | 20747  |                                |                                      | U.                 | .S.A.                              |  |
|                            | deat<br>ms  | Funeral         | 11. Marital Status 1  | 2. Was Decedent Ever in U.S<br>Armed Forces?                   | . 13. V                     | Vas Decedent of Hi   | spanic Origin<br>n. Mexican, P | ? (Specify Yes or uerto Rican, etc.) | No-                | 14. Race - Americ<br>Black, White, |  |
| 9                          | or its  |                 | 1 Never Married 2 Married   | 1 ☐ Yes 2 🔼 No<br>If Yes, Give                                 |                             | ☐Yes 2☑No  | Specify:                       | ,                                    |                    |                                    | BLACK  |
| S                          | within 72 hours atter death with the Maryland ene. ene. rhan "naturat", or items 23e or 28e-f ahow than "Madical Examinat must be notified at   | d by            | 3 Widowed 4 Divorced  | Year or Dates:   |                             |  |                                |                                      | 101 1              |                                    |  |
| ,                          | nation 72 t   | Completed       | 15. Decedent's Educ<br>(Specify only highest grade  | ation<br>completed)  | 16a. Deced                  | lent's Usual Occupa<br>kind of work done o<br>OO NOT use retired | ation<br>during most of        | working                              | 16b. K             | (ind of Business/In                | dustry   |
| 12                         | than<br>than  | ш               | Elementary/Secondary (0-12)   | College (1-4or 5+)   |                             | NONE   | ,                              |                                      | N                  | NONE                               |  |
| 2<br>2                     | Hygir<br>Ther   |                 | 17. Father's Name (First, Middle, Last)   |  |                             | 10212  | 18. Mother's                   | Name (First, Midd                    |                    |                                    |  |
|                            | d be<br>ental   | To Be           | JOHN HARGROVE   |  |                             |  | MARY                           | ROGERS -                             | LANE               |                                    |  |
| <u> </u>                   | is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Menhall Hygiene.  If Health and Menhall Hygiene a fathers!, or Itams 23a or 28a-f show titms 71 is marked other than "natural", or Itams 12a or 28a-f show other traumatic avant, it a Medical Examinar must be notified at | -               | 19a. Informant's Name/Relationship (Typ   | e, Print)  | 19b. Mailin                 | g Address (Street a  | and Number o                   | r Rural Route Nur                    | nber, City         | or Town, State, Zip                | Code)  |
| Š                          | and 2<br>leelth a<br>m 27 is<br>her trau  |                 | ANTIONETTE WILSON   |  | 6501                        | 96th AVE   | NUE LAN                        | NHAM, MAR                            | YLANI              | 20706                              |  |
| •                          | ges 1 a<br>it of Her<br>if Itam<br>or othe  | 1               | 20a. Method of Disposition  | CO.  | ce of Dispor                | sition (Name of natory or other place                            | θ)                             | Date                                 | 20c. L             | ocation - City or To               | own, State   |
| Ë                          | Pages<br>nent of I<br>int: if it  | Į.              | 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)   |  | ERDALE                      | E CREMATO  | RY 6/                          | 30/2006                              | RIV                | ERDALE,M                           | ARYLAND  |
| a                          | permit. Page<br>Department of<br>important: if<br>any injury of<br>once.  |                 | 21. Signature of Funeral Service License  | 1 //   | 22                          | . Name and Addres  | ss of Facility                 | J. B. J                              |                    | S FUNERA                           |  |
| <b>m</b>                   | 20558   |                 | K. D. Mc  | half   |                             | 7474 LAND  | OVER R                         | OAD LANDO                            | OVER,              | MARYLAND                           | 20785  |
|                            |   |                 | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on                            | ations that caused the death.<br>e cause on each line.         | Do not ente                 | er the mode of dyin  | g, such as cai                 | rdiac or respiratory                 | arrest,            |                                    | Approximate<br>Interval Between<br>Onset and Death |
|                            | Physician   |                 | Immediate Cause (Final disease or condition   | HUMAN IMMU   | NODEF1                      | CIENCY V   | IRUS                           |                                      |                    |                                    | Onsot and Death                                    |
|                            | /Medical<br>Examiner  |                 | resulting in death)   | Due to (or as a conseque                                       | ence of):                   |  |                                |                                      |                    |                                    |  |
|                            | LXammer   | L               | Sequentially list conditions, b   | Due to (or as a conseque                                       | on on of):                  |  |                                |                                      |                    |                                    |  |
|                            | ed<br>sslt  | ie<br>E         | Sequentially list conditions, if any, leading to immediate cause. Ents. Underlying Cause (Disease or injury | Due to (or as a conseque                                       | Bilde oij.                  |  |                                |                                      |                    |                                    |  |
|                            | and<br>and<br>Il-trar   | Examiner        | that initiated events c. resulting in death) Last   | Due to (or as a conseque                                       | ence of):                   |  |                                |                                      |                    |                                    |  |
| 8760,                      | rate be executed thy sicien and the burial-transit  | dlcal E         |   |  |                             |  |                                |                                      |                    |                                    |  |
| 687                        | # 5 # #   | ed              |   |  |                             |  |                                |                                      |                    |                                    |  |
| Вох                        | anding<br>use   | M               | IF FEMALE:<br>23b. Was decedent pregnant  | 3c. If yes, outcome of pregnan                                 |                             | Ectopic pregnancy  | ,                              |                                      |                    | 23d. Date of deliv                 |  |
| m.                         | death<br>e atte   | cia             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4 Pregnant at time of dea                                      |                             | Other (specify)  |                                | -                                    | -                  | Month                              | Day Year   |
| P.O.                       | that the death certifi<br>ed by the attending<br>detached for use as  | by Physician/Me | 9 Unknown   | 50-  |                             |  |                                |                                      |                    |                                    |  |
| Ś                          | Se un eg  |                 | Part II. Other significant conditions con   | tributing to death but not resul                               | lting in the ur             | nderlying cause giv  | en in Part I.                  |                                      |                    |                                    | the cause of death? bably 4 😡 Unknown              |
| ord                        | w requir<br>been si<br>should   | Completed       | DECUBITUS ULCERS  |  |                             |  |                                | - '                                  | ∐Yes 2<br>:        | : UNO 3UFIO                        | babiy 4 Monkilowii                                 |
| Ö                          | lawrenes be   | ple             |   |  |                             |  |                                | 24a. W                               | topsy              | prior to co                        | opsy findings available<br>impletion of cause of   |
| <u> </u>                   | The cete h  | S               |   |  |                             |  |                                | 1□ Ye                                | rformed?<br>s 2 No | death?<br>o 1 ☐ Yes                | 21 No  |
| Vita                       | ician<br>Sertifi<br>ector   | Be              | 25. Was case referred to medical examiner?  | ospital:   |                             | Oth  | 00                             | Death (Check on                      |                    |                                    |  |
| of                         | Physician:<br>r this certific<br>ral director,  | 2               | 1X Yes 2 No 27. Manner of Death   | 1 Inpatient 2 LE   | R/Outpatien<br>28b. Time of | IL 3L DOA  | 4 🗆 Nursi                      | ng Home 51 R                         |                    | 6 ☐Other (Speci                    | fy)  |
| LO<br>O                    | ding<br>h.<br>After<br>funer  | ton             | 1 ☑Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year)                       | Injury                      | Wor  | k?<br>Yes 2 □ No               |                                      |                    | ,                                  |  |
| Division of Vital Records, | Attanding r death. actor: After by the fune   | flca            | 3 Suicide 6 Could not be  | 28e. Place of Injury - At hor                                  | me, farm, str               |  |                                |                                      |                    | nd Number or Rur                   | al Route Number,                                   |
| ā                          | after after d in b  | Certification:  | 4  Homicide   | building, etc. (Specify,                                       | )                           |  |                                | City or                              | Town, Stat         | re)                                |  |
|                            | To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Diractor: After this certificete hes completely filled in by the funeral director, page 2   |                 | 29a. Certifier 1 ☐ Certifying Phys<br>(Check only 2 ☑ Medical Examin  | ician: To the best of my know<br>er: On the basis of examinati | vledge, death               | n occurred at the tir  | ne, date and p                 | place, and due to to                 | he cause(s         | s) and manner as a                 | stated.  |
|                            | ths H<br>in 24<br>ths Fi  | ledical         | one)  | and manner stated.   | on and or in                |  |                                |                                      |                    |                                    |  |
|                            | To the complete   | Σ               | 29b. Signature and title of certifier   | 10 -   | 25                          | 29c. Licens  |                                |                                      | 29d. D8            | ate signed (Month,<br>6-28-        |  |
| ,                          |   |                 | year vado   | The sales  | 20                          | 101 100  | 2055                           | 927                                  |                    | 6 00                               | 00   |
| R                          | (2)   | ,               | 30. Name and address of person who co   |  |                             |  | o Char-                        | orla Ma                              | er, 1              | J 2070E                            |  |
| G.                         | C.  | ate             | Salvador Sylves 31. Date filed (Month, Day, Year)   |  |                             |  | e chev                         | етту, ма:                            | Lylan              | u 20/85                            |  |
|                            | Regist  |                 | JUL 0 3 2006  | 22. Registrar's Signat   | Ann                         | Es .   |                                |                                      |                    |                                    |  |

|  |                | For<br>State<br>Registrar  | State of M                    | laryland / De<br><i>C</i>           | partment of I                              |  |   | iene 📗 📗                           | 6 2252   |
|--|----------------|--|-------------------------------|-------------------------------------|--|--|---|------------------------------------|--|
|  | 11             | 1. Decedent's Name (First, Middle, Las   | t)                            |                                     |  |  | 2. Date of Deat<br>Month                    |                                    | 3. Time of Death   |
| Physicia<br>/Medic   |                | Joyce Ann Abe  | 211                           |                                     |  |  | TUNE  | 10 7                               | 006 8:51 PM  |
| Examin   |                | 4a. Fecility Name (If not institution, give  | street and number             | 7)                                  | 4b. City, Town,                            | or Location of Death                         |   | 4c. County of                      | Death  |
|  |                | Doctors Community  | Hospita                       | 1                                   | Lanham                                     |  |   |                                    | George's   |
| Funeral<br>Director  |                | 5. Social Security Number 6. Social Security Number 6. Social Security Number 1    | 9X 7. A<br>□ M 2∏ F           | ge (In yrs. last birthda<br>57 Yrs. | y) If Under 1 Year<br>Months Days          |  | 8. Date of Birth<br>(Month, Day,<br>Nov. 15 | Year                               | . Birthplace (State or Foreig<br>Country)<br>ennsylvania |
| D .  |                | Usual Residence of Decedent  10a, State 10b, County                                |                               | 10c. City, Town or                  | Location                                   |  |   |                                    | 10d. Inside City Limit                                   |
| within 72 hours after death with the Maryland<br>ene.<br>Than "natural", or Items 23e or 28e-f show<br>the Medical Exercities It. ust be notified at   | 5              |  |                               |                                     |  |  |   |                                    | 1 X Yes 2 □ N  |
| Ba-f   | Director       | Maryland Prince C  | eorge's                       | Greenbel                            |  |  | 4   | On Citizen of 18ths                |  |
| Min C  |                | 10e. Street and Number  1-B Research Road  | 1                             |                                     | 10f. Zip Code<br>20770                     |  |   | 0g. Citizen of Wha<br>U . S . A .  | at Country !   |
| 8 23   | era            |  | 12. Was Deceder               | t Ever in 11 S                      | 3. Was Decedent of                         | Historia Origin? (Sr                         |   |                                    | American Indian,   |
| Item<br>Der  | Funeral        | 11. Marital Status 1 ☐ Never Married 2 ☒ Married                                   | Armed Forces                  | 1?                                  | If Yes, specify Cut                        | oan, Mexican, Puerto                         | Rican, etc.)                                |                                    | White, etc.  |
| It's an  | by             | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates |                                     | 1 ☐ Yes 2🎇 No                              | Specify:                                     |   | Specify:                           | White  |
| cal  | ted            | 15. Decedent's Ed  |                               | 16a. De                             | cedent's Usual Occu                        | pation                                       |   | 16b. Kind of Busin                 | ness/Industry  |
| Median.  | Completed      | (Specify only highest gra  | de completed) College (1-40   | life                                | ve kind of work done . DO NOT use retire   | auring most of won<br>ad)                    | ang   |                                    |  |
| Hygiene.<br>Hygiene.<br>Other than   | шо             | cionidinary/oddentally (o 12)  | 2                             | Cook                                |  |  | C   | Cafe Heal                          | th Food Store  |
| s 1 and 2 should be filed within 72 hours after death with the Marylan H Health and Mendal Hygiene. If Health and Mendal Hygiene the firem 23 a or 28a-f show tiem 21 is marked other than "naturat", or Items 23a or 28a-f show other traumatic event, the Medical Examinating and other traumatic event, the Medical Examinating and other traumatic event, the Medical Examinating and other traumatic event, the Medical Examination and the medical events. | Bec            | 17. Father's Name (First, Middle, Last)  |                               |                                     |  | 18. Mother's Nam                             | ne (First, Middle, M                        | Maiden Sumame)                     |  |
| ould be<br>Mental<br>larked o  | To E           | Anthony Pantaleon  | ni                            |                                     |  | Monica I                                     | Hamersky                                    |                                    |  |
| 2 should and Men is marke aumatic  |                | 19a. Informant's Name/Relationship (   | Type, Print)                  | 19b. Ma                             | iling Address (Stree                       | t and Number or Rui                          | ral Route Number                            | , City or Town, Sta                | ate, Zip Code)   |
| Health a Health a tem 27 is  |                | John M. Abell - H  | Husband                       |                                     | Research                                   |  |   | Maryland                           | 1 20770  |
| of Hea<br>of Hea<br>item   |                | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐                            | Damousi from Stat             | cometery c                          | position (Name of<br>rematory or other pla | ice)   | Date  | 20c. Location - Cit                | ry or Town, State  |
| Pages<br>nent of P<br>ant: If its<br>arry or o'  |                | 4 Donation 5 Other (Specify  |                               | Metropo                             | Litan Cre                                  | natory 07/                                   | /03/06 <i>A</i>                             | Alexandri                          | la, Virginia   |
| permit. Pages<br>Department of<br>Important: If it<br>any injury or once.  |                | 21. Signature of Funeral Service Licen   | see /                         | / /                                 | 22. Name and Addr                          | ess of Facility Ga                           | asch's F                                    | uneral Ho                          | ome, P.A.  |
| 80 5 5 8   |                | H Conslan  | ee Da                         | seh                                 | 4739 ва                                    | ltimore A                                    | venue, Hy                                   | yattsvill                          | le, MD 20781   |
|  |                | 23a. Part1. Enter the disease, or com-<br>shock, or heart failure. List only       | olications that caus          | ed the death. Do not line.          | enter the mode of dy                       | ng, such as cardiac                          | or respiratory arre                         | est,                               | Approximate<br>Interval Between                          |
| Physician  |                | Immediate Cause (Final disease or condition  | Pul                           | monar ea                            | un   |  |   |                                    | Onset and Death  |
| /Medical   |                | resulting in death)  | Due to (or a                  | is a consequence of):               | 2  |  |   |                                    |  |
| Examiner   |                | Sequentially list conditions   | b. Con                        | gestin hear                         | + failu                                    |  |   |                                    | le   |
| D #  | Ine            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or é                  | d a consequence of):                |  |  |   |                                    |  |
| licate be executed<br>physician and<br>s the burial-transit  | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last            | C                             | as a consequence of):               |  |  |   |                                    |  |
| oe ex<br>cian (<br>ourial  | Ē              |  | Due to (01 a                  | is a consequence ol);               |  |  |   |                                    |  |
| cate c   | dical          | •  | d                             |                                     |  |  |   |                                    |  |
| death certific<br>attending p  | /Me            | IF FEMALE:   | 23c. If yes, outcom           | ne of oregnancy                     |  |  |   | and Date                           | d dalina a   |
| The law requires that the death certificate has been signed by the attending page 2 should be detached for use a   | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?                                  | 1☐Live birth                  | 2 Fetel death                       | 3 ☐ Ectopic pregnand 5 ☐ Other (specify) _ | :у   |   | 23d. Date of<br>Month              |  |
| the the  | yslc           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 9□ Unknown                    | at time or death                    | Other (specify)                            |  |   |                                    |  |
| res that the death<br>signed by the atter<br>i be detached for u   |                | Part II. Other significant conditions of   | ontributing to death          | but not resulting in the            | underlying cause g                         | ven in Part I.                               | 23e. Did tob                                | pacco use contribu                 | ute to the cause of death?                               |
| sign<br>d be   | d by           | Rund in  | intlian                       |                                     |  |  | 1 □ Ye                                      | s 2 □ No 3[                        | ☐ Probably 4 🔀 Unknow                                    |
| w requir<br>been si<br>should  | ete            |  |                               |                                     |  |  | 24a. Was a                                  | n Jah Wa                           | re autopsy findings availab                              |
| has<br>has   | Completed      |  |                               |                                     |  |  | autops<br>perforr                           | ned? prio                          | r to completion of cause of<br>th?                       |
| certificate<br>ector, pag  |                |  |                               |                                     |  |  | 1 ☐ Yes 2                                   | 2 <b>⊠</b> No 1 □                  | Yes 2 No   |
| ysician: The i<br>s certificate ha<br>director, page   | Be             | 25. Was case referred to medical examiner?   | Hospital:                     |                                     |  | han  | th (Check only on                           |                                    |  |
| Physician:<br>this certificatal director,  | . To           | 1 ☐ Yes 2 🔀 No  27. Manner of Death  | 1 🔀 Inpa                      | tient 2 ER/Outpa                    | IBIL 3 DOX                                 | 4 🗆 INUISING H                               |   | ence 6 Other owninjury occurred    | (Specify)  |
| Jing<br>After<br>fune  | lon            | 1 Natural 5 ☐ Pending  | (Month, L                     | Day Year) Injur                     | y Wo                                       | ork?<br>□Yes 2□No                            | 200. 00001100 110                           | on injury occurred                 |  |
| Attending a death.   | Certification: | 2 Accident investigation 3 Suicide 6 Could not b                                   |                               | njury - At home, farm,              |  |  | 281. Location (St                           | reet and Number                    | or Rural Route Number,                                   |
| or A<br>after<br>Dire  | ertit          | 4 Homicide determined  | building,                     | etc. (Specify)                      | on out, runtory, one                       |  | City or Town                                |                                    |  |
| To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the   | edical C       | (Check only 2 Medical Exar   | ninar: On the basis           | st of my knowledge, do              | eath occurred at the investigation, in my  | ime, date and place,<br>opinion, death occur | , and due to the carred at the time, d      | ause(s) and mannate and place, and | er as stated.<br>I due to the cause(s)                   |
| thin 2<br>the<br>mplel   | Med            | one) 29b. Signature and title of certifier   | and manner                    |                                     | 29c 1 icen                                 | se number                                    | 1 2   | 9d. Date signed (#                 | Month, Dav. Year)  |
| Z Z S  |                | 29b. Signature and title of certifier  | ~ MA                          |                                     | 7  | 4366   | -   | T.1. 1                             | J 2006<br>MD 20902                                       |
| 13   |                |  |                               |                                     | 12   | 7 2746                                       |   | d 414 2                            | , doop   |
| (5)  |                | 30. Name and address of person who   | completed cause o             | death (Item 23a) (Ty                | pe, Print)                                 | 1  | i. i.                                       | Sacin                              | 41 20902   |
|  |                | ROINTAN FARA   | HIFAR                         | 7.0 4801                            | Georgia /                                  | tul Juit 1                                   | - 91 3.10                                   | n spring!                          | D C 102  |
| Sta<br>Regist  | ate            | 31. Date filed (Month, Day, Year)  | 32. Regi                      | strar's Signature                   | 1.   |  |   | _                                  |  |

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State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06/28/2006 **Physician** 7:30 a<sup>M</sup> Tonia Shivers Allgood /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clinton
If Under 1 Year | If Under 24 Hrs. 3513 Chado Rd. Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🖫 F 47 Yrs 577-86-9826 06/09/1959 DC Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other then "natural", or Itams 23e or 28a-1 show other treumstic event, the Modical Examillar must be notified at 1 ☐XYes 2 ☐ No Director MD Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3513 Chado Rd 20735 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Legal Secretary Private 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be h and Mental F Preston Roy Shivers Carol Elizabeth Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Henry D.Allgood/Husband 3513 Chado Rd.Clinton,MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 07/03/06 Suitland, MD Lincoln Cemetery | injury 22. Name and Address of Facility Taylor's Funeral Home 21. Signature of Funeral Service Licensee any. 1722 N. Capitol St. NW Washington, DC 23a. Part1. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death JARIA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of): Physiclan/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy 1 Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Signed (Month, Day, Year) D354 29b. Signal Name and a D BRAUCITAUE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUL 0 3 2006

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|                   |  |                | 1 - For<br>State<br>Registrar  | State of N  | Maryland                          |                     |               | nt of H<br>te of L                      |  | nd Me                   |                               | jiene<br>og. No. C                               | 2006  | 22                         | 527        |
|-------------------|--|----------------|--|---|-----------------------------------|---------------------|---------------|---|--|-------------------------|-------------------------------|--|---|----------------------------|------------|
|                   |  |                | 1. Decedent's Name (First, Middle, Li                                    | ast)  |                                   |                     |               |   |  | 2                       | . Date of Dea<br>Month        | th<br>Day  | Year  | 3. Time of                 |            |
|                   | Physicia<br>/Medic   |                |  | nderson   |                                   |                     |               |   |  |                         |                               | 25   | 2006  | 8:05                       | рм         |
| )                 | Examin   |                | 4a. Facility Name (If not institution, gi                                |   | er)                               |                     | _ ′           |   | Location of  | Death                   |                               | 4c. C  | ounty of Death  |                            |            |
|                   |  |                | Southern MD Ho   |   | Age (in yrs. ia                   | at hirthday)        |               | Clin<br>or 1 Year                       | ton  | 4 Hrs.   o              | . Date of Birth               |  | PG  | place (State o             | or Formian |
|                   | Funeral<br>Director  |                | 5. Social Security Number 6. 577-42-8777                                 | 1 M 2X F  | 8 Aye (III yis. Ia                |                     | Months        |   | Hours  | Min.                    | (Month, Day                   | , Year)  | Cor   | intry)                     | # Foreign  |
|                   |  |                | Usual Residence of Decedent  |   |                                   |                     |               |   |  |                         | 2/18/                         | 1920   | was.  | n. DC                      |            |
|                   | yland<br>Now   |                | 10a. State 10b. County   | 20  | 10c. City                         | , Town or Lo        |               | 1 7                                     |  |                         |                               | 10d. Inside City Limits 1 1 1 1 1 1 1 1 2 1 1 No |   |                            |            |
|                   | Mar<br>a-f-et  | Director       | MD   | PG  |                                   | Ten                 | ıpLe          | Hil                                     | ls   |                         |                               |  |   | 1 ∑Yes                     | 2 🗌 No     |
|                   | or 28  | lre            | 10e. Street and Number   |   |                                   |                     | 10f. Z        | ip Code                                 |  |                         | 1                             | 0g. Citize                                       | n of What Co  | intry?                     |            |
|                   | th wi  |                | 5100 Acorn Dr  | •   |                                   |                     |               | 207                                     |  |                         |                               |  | USA   |                            |            |
|                   | r dea  | Funerai        | 11. Marital Status   | 12. Was Decede<br>Armed Force                             | is?                               | 6. 13.              | Was Dec       | edent of Hi                             | spanic Orig<br>n, Mexican,   | in? (Speci<br>Puerto Ri | fy Yes or No-<br>can, etc.)   | 14   | <ul> <li>Race - Amer</li> <li>Black, White</li> </ul> |                            |            |
| 36                | s afte   | by Fu          | 1 Never Married 2 Married  | 1 ☐ Yes 25  |                                   |                     | 1 🗌 Yes       | <b>≥€</b> No                            | Specify:   |                         |                               | s  | pecify: B1  | ack                        |            |
| 21215-0036        | within 72 hours after death with the Maryland<br>ene.<br>Then "natural" or items 23a or 28a-f ehow<br>he Madical Exarding noust be notified at                     | D D            | 3 ☑ Widowed 4 □ Divorced  15. Decedent's f                               | Year or Date  | s:                                | 16a. Dece           | lant's Hs     | ual Occupa                              | ation  |                         |                               | 16h Kino   | f of Business/l                                       | ndustry                    |            |
| 75                | n 72   | lete           | (Specify only highest g  | rade completed)   |                                   | (Give               | kind of w     | ork done d                              | luring most  | of working              | '                             | TOD. KING  | 0 00311103321   | idustry                    |            |
| 12                | filed within 72 ho<br>Hygiene.<br>Ither then "natur<br>ent, the Madical  | Completed      | Elementary/Secondary (0-12)  | College (1-4d   | or 5+)                            |                     | Нс            | usev                                    | ife  |                         |                               |  | Priv  | ate                        |            |
| D                 | 를 갖고 다   | BeC            | 17. Father's Name (First, Middle, Las                                    | it)   |                                   |                     |               |   | 18. Mother   | 's Name (i              | First, Middle,                | Maiden S   | umame)  |                            |            |
| Maryland          | should be filed<br>and Mental Hygi<br>s marked other<br>umatic event, I  | To B           | Samuel   |   | son                               | 405 14-35           | - 4 4 4       | (0)                                     |  | ene                     |                               |  | Davis   | in Code)                   |            |
|                   | Ith ar<br>27 is<br>r trau  |                | 19a. Informant's Name/Relationship<br>William Anders                     |   |                                   |                     | -             |   |  |                         |                               |  | Town, State, Z<br>MD 20                               |                            |            |
| Baltimore,        | iges 1 ar<br>nt of Hea<br>iffitem<br>or othe   |                | 20a. Method of Disposition   |   | 1 00                              | ace of Dispo        | sition (N     | ame of<br>other place                   | e)   | Dat                     | te                            | 20c. Loca  | ation - City or 1                                     | own, State                 |            |
| Ē                 | Pages<br>nent of I<br>int: if its<br>iry or o  |                | 1 ☐ Burial 2√☐ Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spec               |   | ite                               | -                   | -             |   |  | 07-0                    | 3-06                          | Rive   | erdale  | MD                         |            |
| alti              | permit. Page<br>Department of<br>Important: if<br>eny injury or<br>once.   |                | 21. Signature of Funeral Service Lie                                     | ensee A   |                                   |                     |               |   |  |                         |                               |  | II F  |                            | h.         |
| m                 | 88.58  |                | 10.0.6   | Die   | <u> </u>                          | 1                   | 0583          | Mid                                     | ldlep  | ort                     | Lane.                         | , Wh   | ite P   | lains                      | , MD       |
|                   |  |                | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on | mplications that cause on each                            | sed the death<br>n line.          | . Do not ent        | er the mo     | de of dyin                              | g, such as o   | cardiac or i            | respiratory arr               | est,   |   | Approximat<br>Interval Bet | tween      |
|                   | Physician  |                | Immediate Cause (Final disease or condition                              | . (1  | Rose                              | DCIS                |               |   |  |                         |                               |  |   | Onset and                  |            |
|                   | /Medical   |                | resulting in death)  |   | RoSe<br>as a consequ              |                     | -             |   |  |                         |                               |  |   |                            | 1          |
| Н                 | Examiner   |                | Sequentially list conditions,  | b. A1   | Theresc                           | lenotic             | Car           | ediou                                   | anular   | - Di                    | Sean                          |  |   | 59                         | Raw        |
|                   | D #  | Examiner       | if any, leading to immediate cause. Enter Underlying                     | Due to (or  | as a consequ                      | ence of):           |               |   |  |                         |                               |  |   |                            |            |
|                   | and<br>-trans  | cam            | Cause (Disease or injury that initiated events resulting in death) Last  | C. Due to /or   | as a consequ                      | lence of):          |               |   |  |                         |                               |  |   |                            |            |
| 60,               | cate be executed obysicien and the burial-transit  |                |  | 200 10 (01  | as a consequ                      | once on.            |               |   |  |                         |                               |  |   |                            |            |
| 8760,             | physi<br>the   | dicai          | S  | d   |                                   | •                   |               |   |  |                         |                               |  |   |                            |            |
| 9 X               | leath certifica<br>attending ph<br>for use as th   | Physician/Me   | IF FEMALE:   | 23c. If yes, outcor                                       | me of pregnar                     | ncy                 |               |   |  |                         |                               | 23   | d. Date of deli                                       | /erv                       |            |
| Box               | atten<br>for u   | cian           | 23b. Was decedent pregnant in the past 12 months?                        | 1 ☐ Live birth  | n 2 ∏ Fetal<br>tat time of de     | death 3[            | Ectopic Other | pregnancy<br>specify)                   |  |                         |                               | -  | Month   |                            | Year       |
| o.                | at the de<br>by the a  | ysi            | 1 ☐ Yes 2X ☐ No<br>9 ☐ Unknown   | 9□ Unknow   |                                   |                     |               |   |  |                         |                               |  |   |                            |            |
| σ.                | The law requires that the death certificate be executed the has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit | by Pt          | Part II. Other significant conditions                                    | contributing to deat                                      | h but not resu                    | Ilting in the u     | nderlying     | cause give                              | en in Part I.  |                         | 23e. Did to                   | bacco use  | e contribute to                                       | the cause of o             | death?     |
| of Vital Records, | w require:<br>been sig<br>should b   |                |  |   |                                   |                     |               |   |  |                         | 1 □ Y                         | es 2 🗌   | No 3∏ Pro   | bably 47Q                  | Unknown    |
| 00                | s bee  | plet           |  |   |                                   |                     |               |   |  |                         | 24a. Was a                    |  | 24b. Were au  | topsy findings             | available  |
| æ                 | The lav  | Completed      |  |   |                                   |                     |               |   |  |                         | autop.<br>perfor              | med?<br>2 ⊠ No                                   | death?  | 2 PNo                      | .au36 01   |
| ita               |  | 0              | 25. Was case referred to medical   |   |                                   |                     |               |   | 26. Place  | of Death (              | Check only or                 |  |   | - <del>X</del>             |            |
| <b>†</b> <        | S S  | To B           | examiner?<br>1 ☐ Yes 2 ☑ ♠ 0   | Hospital: 1 1 Inp.  | atient 2 🗆 l                      | ER/Outpatie         | nt 3 🗆 🛭      | Oth                                     | er: 4 □ Nu   | rsing Home              | 5 ☐ Resid                     | ence 6   | □Other (Spec  | ify)                       |            |
| 0                 | ng Ph<br>tter th<br>neral  |                | 27. Manner of Death 1≯⊠ Natural 5 ☐ Pending                              | 28a. Date of I<br>(Month,                                 | njury<br>Day Ye <i>ar)</i>        | 28b. Time of Injury | f             | 28c. Injun<br>Work                      | at<br></td <td>28</td> <td>d. Describe h</td> <td>ow injury</td> <td>occurred</td> <td></td> <td></td> | 28                      | d. Describe h                 | ow injury  | occurred  |                            |            |
| Ö                 | Attending r death. ector: After by the funer   | atic           | 2 Accident investigat  |   |                                   |                     | М             | 10                                      | Yes 2 N  |                         |                               |  |   |                            |            |
| Division          | i or Attendin<br>after death.<br>Director: Af<br>in by the fur   | Certification: | 3 Suicide 6 Could not<br>4 Homicide determine                            | A 286. Place of   | Injury - At ho<br>, etc. (Specify | me, farm, st        | reet, facto   | ory, office                             |  | 28                      | f. Location (S<br>City or Tow | treet and<br>n, State)                           | Number or Ru  | ral Route Nun              | ıber,      |
|                   | urs al<br>urs al<br>srai D   | Ce             |  | Sharinian Tashah  | at at an . I a                    | dadaa daa           | <u> </u>      | d - 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 |  | 1 -1                    | al alice to the               |  |   |                            |            |
|                   | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral                        | edical         |  | Physician: To the be<br>aminer: On the basi<br>and manner | s of examinat                     |                     |               |   |  |                         |                               |  |   |                            | s)         |
|                   | To th<br>To th<br>comp   | Me             | 29b. Signature and title of certifier                                    |   |                                   |                     |               | 9c. Licens                              |  |                         |                               |  | signed (Monti   |                            |            |
|                   | _  |                | In Soll  |   |                                   |                     |               | 09                                      | c 536  | 5                       |                               | 01   | 5-26-2  | 000                        |            |
| 0                 |  |                | 30. Name and address of person wh  | o completed cause   | of death (Item                    | 23а) (Туре,         | Print)        | 0.                                      | c a. / 1   | f                       | MAZ                           | 71   | • .   |                            |            |
| 1-                | - 0  |                | Michael Sidanous, or   | 2 1170 1  | ivingsta                          | - pul to            | -101/         | Sout a                                  | As ho.   | y ton                   | 11/20                         | 149  | 7   |                            |            |
|                   | Sta<br>Regist  | ate<br>rar     | 31. Date filed (Month, Day, Year)  | 32. Reg   | istrar's Signal                   | lure Local          | 2             |   |  |                         |                               |  |   |                            |            |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene On Co

|                     |   |                | For<br>Stete<br>Registrar   | State of Ma   | •                                   | partment of H                               | lealth and Meni<br>D <i>eath</i>                      | tai Hygien<br>Reg. N                 | 4000                             | 22528  |
|---------------------|---|----------------|---|---|-------------------------------------|---|---|--------------------------------------|----------------------------------|--|
|                     | Dhariai   |                | 1. Decedent's Name (First,  | , Middle, Last)   |                                     |   | 2, 0  | Date of Death                        | av Year                          | 3. Time of Death                                   |
|                     | Physicia<br>/Medic  |                | Lawrer  |   | 5 2/6                               |   | 0   | 06 2                                 | 26 2006                          | 1238 M   |
| 1                   | Examin  | er             | 4a. Facility Name (If not ins   | stitution, give street and number)  | st Ho                               | 4b. City, Town, or                          | Koma Pa   | IK I                                 | County of Death                  | meny   |
|                     | Funeral   |                | 5. Social Security Number C   | 6. Sex 7. Age   | (In yrs. last birtho                | Months Days                                 | If Under 24 Hrs. 8. D<br>Hours Min. (/                | Date of Birth<br>Month, Day, Yea     | ar) 9 Birth                      | place (State of Foreign                            |
|                     | Director  |                | 577-66-965<br>Usual Residence of Decede   |   | 26 Yrs                              |   | Se  | ept 18,                              | 1949DC                           |  |
|                     | ryland  |                |   | County  | 10c. City, Town o                   |   |   |                                      |                                  | 10d. Inside City Limits                            |
|                     | he Ma<br>28a-f s  | Director       | Md PG  10e. Street and Number   |   | Suitlan                             | 10f. Zip Code                               |   | 100 (                                | Citizen of What Cou              | 1X Yes 2 □ No                                      |
|                     | 3a or 3   |                | 2319 Wynga  | ate Road  |                                     | 20746                                       |   | US                                   |                                  | nuyr   |
|                     | ems 2   | Funeral        | 11. Marital Status  | 12. Was Decedent E<br>Armed Forces?   | ver in U.S.                         |   | ispanic Origin? (Specify<br>in, Mexican, Puerto Ricar |                                      | 14. Race - Ameri<br>Black, White |  |
| 36                  | s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then 27 Is marked other than "natural; or Items 23e or 28e-f show other traumatic event. It is Medical Exam. Let must be notified at | þ              | 1 ☐ Never Married 2 ☐<br>3 ☐ Widowed 4 🛣 Div  | If Yes Give   |                                     | 1□ Yes 2√2 No                               | Specify:  |                                      | Specify: Bla                     | ick  |
| Maryland 21215-0036 | 72 hou<br>natura  | Completed      | 15. De<br>(Specify only   | ecedent's Education<br>y highest grade completed)                                     | 16a. De                             | ecedent's Usual Occup                       | ation<br>during most of working                       | 16b.                                 | Kind of Business/Ir              | ndustry  |
| 121                 | within<br>ene.<br>than  | mp             | Elementary/Secondary (  |   | +)                                  | e. DO NOT use retired<br>chanic             | 1)  | DC                                   | C Govt                           |  |
| d 2                 | e filed within al Hygiene. I other than vent, the Ne  | Be Co          | 12th<br>17. Father's Name (First, N   |   | 1100                                | J. C.   | 18. Mother's Name (Fire                               |                                      |                                  |  |
| ylar                | 2 should be<br>and Mental<br>Is marked of<br>aumatic eve  | ToE            | Nathan B  |   |                                     |   | Florence  | <del>-</del>                         |                                  |  |
| Mar                 | d 2 sh<br>th and<br>th and<br>7 Is m<br>traum   |                | 19a. Informant's Name/Rei   | elationship <i>(Type, Print)</i><br>. Bland Jr(So                                     |                                     |   | and Number or Rural Rou                               |                                      |                                  |  |
|                     | s 1 and 2<br>of Health a<br>item 27 ls<br>other train   |                | 20a. Method of Disposition  | 1   | 20b. Place of D                     | sposition (Name of crematory or other place | Or.#212 Fo  | 20c.                                 | Location - City or T             | own, State   |
| Baltimore,          | Pages<br>ment o<br>lent: If i   |                | `4 Donation 5 Do  |   |                                     | ection Ce                                   | m 07-03-0   | 06 C1                                | inton Mo                         |  |
| Ball                | permit. Pages 1 an<br>Department of Heal<br>Importent: If item 2<br>any injury or other<br>once.  |                | 21. Signature of Funeral S  | Pervice License Wurs  | rel                                 | 22. Name and Addre<br>Tyrone J.             | ss of Facility Young 71                               | 9 Kenn                               |                                  | ngton,DC<br>NW 20011                               |
| Ţ                   |   |                | 23a. Part1. Erver the disea<br>shock a heart failure  | ease, or complications that caused<br>re. List only one cause on each lin             | the death. Do not                   | enter the mode of dyin                      | g, such as cardiac or res                             | piratory arrest,                     | 1                                | Approximate<br>Interval Between<br>Onset and Death |
|                     | Physician<br>/Medical   |                | Immediate Cause (Final disease or condition resulting in death)   | a. 40   | ute                                 | Myoca                                       | rdiaL   | Lnje                                 | ercho                            | 2  |
|                     | Examiner  |                | 0   | Ce  | a consequence of)                   | ry Fr                                       | teny;   | 77151                                | ases                             |  |
|                     | be sit  | iner           | Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury | Due to (or as a   | a consequence of)                   |   |   |                                      |                                  |  |
| ,                   | tificate be executed<br>g physician and<br>as the burial-transit  | Examiner       | that initiated events<br>resulting in death) Last   | C   | a consequence of):                  |   |   |                                      |                                  |  |
| 68760               | nte be<br>nysician<br>ne buri   | edical         |   | d   |                                     |   |   |                                      |                                  |  |
|                     |   |                | IF FEMALE:  | 23c. If yes, outcome  | of pregnancy                        |   |   |                                      | 001 D 1 1 1 1 5                  |  |
| Box                 | that the death certi<br>ed by the attending<br>detached for use a   | Physician/M    | in the past 12 months  1 Yes 2 No   | nant 1 Live birth<br>es? 4 Pregnant at  | 2 Fetal death                       | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)   | ·   |                                      | 23d. Date of deliv<br>Month      | Day Year   |
| P.0                 | that the de<br>led by the a<br>detached f   | Phys           | 9 🗆 Unknown   | 9 Unknown   | at a st as a still a line th        |   | on in Book  | 22a Did tabaaa                       | o use contribute to              | the sauce of death?                                |
| rds,                | sign<br>d be  | ed by          | 1/  | conditions contributing to death by   | FIDY                                | la 170                                      |   | 1 Tes                                |                                  |  |
| Records,            | has t   | Completed      |   |   |                                     |   |   | 24a. Was an autopsy performed 1 Yes  | prior to co                      | opsy findings available ompletion of cause of      |
| Vital               |   | BeC            | 25. Was case referred to examiner?  |   |                                     |   | 26. Place of Death (Ch                                |                                      |                                  |  |
| of                  | Phys<br>r this<br>ral dir   | 1.70           | 1 Yes 2 No  | Hospital: 1 ☐ Inpatie   |                                     | atient 3 DOA Oth                            | 4 Nursing Home  | 5 Residence                          |                                  | fy)  |
| ion                 | Attending I<br>r death.<br>ector: After<br>by the funer   | atior          | 2 Accident  | Pending (Month, Day investigation   | Year) Inju                          | ry Wor                                      | k?<br>Yes 2 □ No                                      |                                      |                                  |  |
| Division            | l or Atten<br>after deat<br>Director:   | Certification: | 3 Suicide 6 4 Homicide  | Could not be determined 28e. Place of Injubulding, etc                                | ury · At home, farm<br>c. (Specify) | , street, factory, office                   |   | ocation (Street<br>City or Town, Sta | and Number or Rur<br>ate)        | al Route Number,                                   |
|                     | To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by  | edical C       |   | Certifying Physician: To the best of Medicel Examiner: On the basis of and manner sta | examination and/o                   |   |   |                                      |                                  |  |
|                     | To the within 2 To the complet  | Me             | 29b. Signature and title of   |   | 7                                   | 29c. Licens                                 | e number  | 29d. [                               | Date signed (Month,              | Day, Year)   |
|                     | 1   |                | > Slao  | SOFT OF   | >                                   | DI  | 206179  | 9 0                                  | 6/26                             | 106  |
|                     | (4)   |                | 30. Name and address of   | person who completed cause of   | eath (Item 23a) (Ty                 | (11)  | Washir  | petor                                | Adu                              | intist 1   |
|                     | Sta   | te             | 31. Date filed (Month, Day  |   | ar's Signature                      | Ta  | koma park   | Md.209                               | 12 //                            | spital   |
|                     | Registi   | ar             | JUL 0 3   | 3 2006 Steeler  | N April                             | while the                                   |   |                                      |                                  |  |

| 0 | $\alpha$ | -  | 0 | C |
|---|----------|----|---|---|
| / | /        | .) |   | 1 |

|  |   | State     Registrar  1. Decedent's Name (First, Middle, Last  | ()   |  |  |  | 2. Date of Dea   | Reg. No.<br>ath  |   | 3. Time of D   |
|--|---|---|--|--|--|--|--|--|---|--|
| Physic   | ian   |   |  | lon C-   |  |  | Month  | Day  |   | ar   |
| /Med   |   | Gene Girard V  4a. Facility Name (If not institution, give  |  | len, Sr.   | 4b. City, Town, or   | Location of Death  |  | 11,  | 2006<br>County of D   | 6:05 p   |
| Exami  | ner   | St. Mary's Hospit   |  |  | ,,   | nardtown   |  |  |   | Mary's   |
| Funeral  |   | 5. Social Security Number 6. Se   |  | (In yrs. last birthday,  | If Under 1 Year  | If Under 24 Hrs.   | 8. Date of Birt<br>(Month, Da)   | th   |   | Birthplace (State or Country)  |
| Director   |   | 225-54-2500   | <b>X</b> M 2□F   | 64 Yrs.  | Months Days  | Hours Min.   | Oct.31   | , 19   | 41  | Virginia   |
| one.<br>then "ratural" or items 23a or 28a-f show<br>re-Modical Examinatival be notified at  |   | 10a. State 10b. County  |  | 10c. City, Town or L   | ocation  |  |  |  |   | 10d. Inside City   |
| 트를   | tor   | Maryland St. Ma   | arv's  |  | Mechan   | icsville   |  |  |   | 1 ☐ Yes  |
| r 288  | Director  | 10e. Street and Number  |  |  | 10f. Zip Code  | 2001211  |  | 10g. Cit   | izen of Wha   | t Country?   |
| 23a o  | a D   | 26320 Loveville I   | Road   |  | 206  | 59   |  | Un   | ited  | States   |
| E E  | Funeral   | 11. Marital Status  | 12. Was Decedent E<br>Armed Forces?  | ver in U.S. 13.  | Was Decedent of Hi<br>If Yes, specify Cuba   | spanic Origin? (Sp<br>n. Mexican, Puerto   | pecify Yes or No-  |  | 14. Race - A  | American Indian,<br>Vhite, etc.  |
| ial Hygiene.<br>«d other then "natural", or liems 23s or 28s-f show<br>event, its Medical Examinat i wat be notified at  | by  | 1 Never Married 2 Married 3 Widowed 4 Divorced  | 1 ☐ Yes 2 🛣 No<br>If Yes, Give<br>Year or Dates:   |  | 1 ☐ Yes 2X No  |  | 7 110211, 510.7  |  | Specify:  | Black  |
| ice i  | Completed   | 15. Decedent's Edi  | ucation  | 16a. Dece  | edent's Usual Occupa   | ition  | kına   | 16b. K   | ind of Busini   | ess/industry   |
| Med 7  | ple   | Elementary/Secondary (0-12)   | College (1-4or 5+  | life.  | e kind of work done of<br>DO NOT use retired   | l most of wor  | \mg  |  |   |  |
| Hygiene.<br>other ther   | Con   | 12  |  |  | Carpenter  |  |  |  |   | ruction  |
| nd Mental Hygiene.<br>marked other then<br>imatic event, Ira M   | Be  | 17. Father's Name (First, Middle, Last)   |  |  |  | 18. Mother's Nam   |  |  |   |  |
| Mental I<br>varked o   | To  | Hartwell Allen  |  |  |  |  | ia Eliza   |  |   |  |
| Is m   |   | 19a. Informant's Name/Relationship (T   |  | 1  | ing Address (Street a  |  |  |  |   |  |
| if Health and Menitem 27 is marked other treumatic   |   | Barbara A. Allen 20a. Method of Disposition   | / wire   | 20b. Place of Disp   | D Lovevill osition (Name of  |  | Date   |  |   | or Town, State   |
| 0  | 1   | 1 ☐ Burial 2 X Cremation 3 ☐  |  | cemetery, cre  | matory or other place  | 9)   | 13   |  |   |  |
| 원린군  |   | 4 □ Donation 5 □ Other (Specify,  | A  |  | ld-Echols 2. Name and Addres   |  | the state of the s |  |   |  |
| Depe<br>Impo   |   | Edward N. Brinsfi   | 2/   |  | 2955 Holly   |  |  |  |   | _  |
|  |   | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of   | olications that caused to<br>one cause on each line  | the death. Do not en<br>e.   | iter the mode of dying   | , such as cardiac  | or respiratory ar  | rrest,   |   | Approximate<br>Interval Betw   |
| ysician  |   | Immediate Cause (Final disease or condition   | Respirate  | ory Failur   | re   |  |  |  |   | Onset and De   |
| /ledical   |   | resulting in death)   | g  |  |  |  |  |  |   |  |
|  |   | Tooland in docum  | Due to (or as a  | consequence of):   |  |  |  |  |   |  |
|  |   | -1407-450000 -400400000000000   | Acute Res  | spiratory  |  | Syndrome   |  |  |   | 24 hours   |
| aminer   |   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  | b Acute Res  | spiratory consequence of):   | Distress   |  |  | 1 - 6  |   |  |
| caminer  |   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  | b Acute Res  | spiratory consequence of):   | Distress   |  |  | 1 Ef   | fusio   |  |
| cien and burial-transit  | Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | b Acute Res  | spiratory consequence of): cer (Metas  | Distress   |  |  | l Ef   | fusio   |  |
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| been signed by the attending physicien and should be detached for use as the burial-transit  | by Physician/Medical Examiner                                       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a c. Lung Cane Due to (or as a d   | spiratory a consequence of):  cer (Metas a consequence of):  of pregnancy 2   Fetal death 3( time of death 5(  at not resulting in the attrointesti  | Distress static) wi  Ectopic pregnancy Other (specify) underlying cause give   | th Right nin Part!   | Pleura.  | obacco u   | 23d. Date of<br>Month<br>use contribu   | delivery Day Ye te to the cause of de  |
| has been signed by the attending physicien and the burial-transit to a should be detached for use as the burial-transit to the same than the burial-transit to the burial-transit to the same than the s | by Physician/Medical Examiner                                       | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions on Renal Failure, And Deep Vein Thrombot   | Due to (or as a c. Lung Cando Due to (or as a d  | spiratory a consequence of):  cer (Metas a consequence of):  of pregnancy 2   Fetal death 3( time of death 5(  at not resulting in the attrointesti  | Distress static) wi  Ectopic pregnancy Other (specify) underlying cause give   | th Right nin Part!   | 23e. Did to  | obacco u<br>Yes 2  | 23d. Date of Month  use contribut  No 3 [  24b. Wern prior deat   | delivery Day Ye te to the cause of de Probably 4XUr e autopsy findings avito completion of cai   |
| sale has been signed by the attending physicien and property provided by the attending physicien and property provided by the attending physicien and provided by the purial-transit provided for use as the burial-transit  | e Completed by Physician/Medical Examiner                           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  | Due to (or as a c. Lung Cando Due to (or as a d  | spiratory a consequence of):  cer (Metas a consequence of):  of pregnancy 2   Fetal death 3( time of death 5(  at not resulting in the attrointesti  | Distress static) wi  Ectopic pregnancy Other (specify) underlying cause give   | th Right nin Part!   | 23e. Did to 1 1 1 24a. Was autop period 1 1 Yes  | obacco u<br>Yes 2<br>an<br>an<br>obsy<br>rmed?   | 23d. Date of Month  use contribut  No 3 [  24b. Wern prior deat   | delivery Day Ye te to the cause of de Probably 4XUr e autopsy findings avito completion of cai   |
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| fer death, rector: After this certificate has been signed by the attending physicien and inector. After this certificate has been signed by deached for use as the burial-transit by the funeral director, page 2 should be detached for use as the burial-transit.  | To Be Completed by Physician/Medical Examiner                       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  | Acute Resolve to (or as a c. Lung Cando Due to (or as a c. Lung Ca | spiratory consequence of): cer (Metas consequence of): of pregnancy consequence of): of pregnanc | Distress  Static) wi  Ectopic pregnancy Other (specify)  underlying cause give inal Bleed  H/O Larynx  ont 3 DOA Other  28c. Injury Work M 1 To  treet, factory, office  | in in Part I. ing Cancer  26. Place of Dea Cancer | 23e. Did to 1 24a. Was autop performed at the time.  | obacco u Yes 2 an Day rmed? 22 No one dence how injure Street an one cause(s) date and | 23d. Date of Month  Use contribution  I No 3 [  24b. Wern prior deat 1   1   1   1   1   1   1   1   1   1                            | delivery Day Ye te to the cause of de Probably 4X Ur e autopsy findings av the completion of cai h? Yes 2X No  Specify)  or Rural Route Numb |
| Ison death.  Iterator: After this certificate has been signed by the attending physicien and interestor: After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit   | edical Certification: To Be Completed by Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  | Acute Resolve to (or as a c. Lung Cando Due to (or as a c. Lung Ca | spiratory consequence of): cer (Metas consequence of): of pregnancy consequence of): of pregnanc | Distress  Static) wi  Ectopic pregnancy Other (specify)  underlying cause give Inal Bleed  H/O Larynx  ent 3 DOA Other of 28c. Injury Work M 1 Ctreet, factory, office  the occurred at the times the state of the course of the c | in Part I. ing Cancer 26. Place of Dea at 27. fes 2 \sum No  | 23e. Did to 1 1 1 1 1 2 2 4 a. Was autop performance of the Check only of the Check  | obacco u Yes 2 an ssy rrmed? XX No one dence how injure cause(s) date and 29d. Date    | 23d. Date of Month  use contribut  No 3 [  24b. Went prior deat 1 [  6 [Other () occurred of Number of place, and the signed (Month)] | te to the cause of de Probably 4XUr e autopsy findings an to completion of cau h? Yes 2X No  Specify)  Translated. due to the cause(s)       |
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|                            |  |                               | State Registrar   | ite of Maryland  | d / Depa                        |   |   | Mental Hy  | -                                | 006  | 22530  |
|----------------------------|--|-------------------------------|---|--|---------------------------------|---|---|--|----------------------------------|--|--|
|                            | Physici<br>/Medic  | _                             | 1. Decedent's Name (First, Middle, Last)  | Al   | iH                              |   |   | 2. Date of Dea                                   | Day                              | 2006   | 3. Time of Death   |
|                            | Examin<br>Funeral  | er                            | 4a. Fecility Name (If not institution, give street.  Shady Grove  5. Social Security Number  6. Sec. 11 M 2   | e Advent   |                                 | 4b. City, Town, o   | RIM   |  |                                  | ntgom<br>9. Birthple<br>Count                              | ery<br>ace (State or Foreign<br>ry) NY                   |
|                            | Director<br>Moye   |                               | Usual Residence of Decedent  10a. State 10b. County  FL Palm Beach  | 10c. City  | , Town or Loc                   |   |   |  |                                  |  | d. Inside City Limits 1X Yes 2 □ No                      |
|                            | with the Manager of the results  | I Direct                      | 10e. Street and Number<br>5678 Emarld Cay Te:   |  |                                 | 10f. Zip Code<br>3343   | 7   |  | 10g. Citizen of                  | What Count<br>US   |  |
| 960                        | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28s-f show many loury or other traumatic avant, the Medical Examinant must be notified at once. | Completed by Funeral Director | 1 Never Married 2 Married 1   | as Decedent Ever in U.S<br>med Forces?<br>] Yes 2 X No<br>/es, Give<br>aar or Dates:   |                                 | /as Decedent of H<br>Yes, specify Cub                                 | fispanic Origin? (Span, Mexican, Puerto<br>Specify: | pecify Yes or No-<br>o Rican, etc.)              | 14. Ra<br>Bla<br>Speci           | ace - America<br>ack, White, e                             |  |
| 21215-0036                 | d within 72 ho<br>piene.<br>r then "netu   | ompleted                      | 15. Decedent's Education (Specify only highest grade com, Elementary/Secondary (0-12)  Co 2   | oleted)<br>illege (1-4or 5+)   | (Give F<br>life. D              | ent's Usual Occup<br>kind of work done<br>O NOT use retire<br>e Maker | pation<br>during most of wor<br>d)                  | king   | 16b. Kind of I                   |  | ustry  |
| Maryland 2                 | ould be filed<br>Mental Hyg<br>Marked othe   | To Be C                       | 17. Father's Name (First, Middle, Last)  Max Lerner   | ,  |                                 |   |   | Bindman  |                                  | <i>,</i>   |  |
|                            | and 2 sh<br>salth and<br>n 27 le m   |                               | 19a. Informant's Name/Relationship (Type, Pr<br>Alan Shulman (Son-i   | n-law)   | 11217                           | Lake Br   | and Number or Au                                    | ve North   | Potoma                           | ac MD  | 20878  |
| Baltimore,                 | Pages 1<br>nent of Hi<br>ant: If Iter  |                               | 20a. Method of Disposition  1   | ol from State  | emetery, crem<br>ernal L        |   | etery 7/0   |  | Boynton                          | n Beac   | h FL   |
| Balt                       | permit. Departi  |                               | 21. Signature of Funeral Service Licenses   |  |                                 |   | ess of Facility Danc. 1170                          | _  |                                  | Rockv  | ille MD  |
| į.                         | Physician<br>/Medical  |                               | 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one caulimmediate Cause (Final disease or condition resulting in death) | s that caused the death<br>se on each line.  Septic  Due to (or as a consequ   | Sh                              | or the mode of dying  | ng, such as cardiac                                 | or respiratory ar                                | rest,                            |  | Approximate 20852<br>Interval Between<br>Onset and Death |
| 3760,                      | ate be executed hysicien and he burial-transit   | Ilcal Examiner                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events                         | Due to (or as a consequence to (or a))). | rtera                           |   | schen   |  | ape                              | 1  | 1 week   |
| P.O. Box 68                | igned by the attending physicien and igned by the attending physicien and be detached for use as the burial-transit  | Physician/Med                 | in the past 12 months?  | yes, outcome of pregnar<br>□Live birth 2 □ Fetal<br>□ Pregnant at time of de<br>□ Unknown  | death 3 🗆                       | Ectopic pregnanc<br>Other (specify) _                                 | у   |  |                                  | ate of deliver   | y<br>Day Year  |
|                            | The law requires that the tite bes been signed by this age 2 should be detache   | ted by Pt                     | Part II. Other significant conditions contribute  ARDS CHF  | 01-  |                                 | derlying cause giv  |   | 23e. Did to                                      | V                                |  | e cause of death?  |
| Il Reco                    | (0 TT  | Completed by                  | fractures,  | HTO  |                                 |   |   | 24a. Was<br>autop<br>perfo<br>1 \( \text{Yes} \) | sy                               | Were autop<br>prior to com<br>death?<br>1 \( \text{Yes} \) | sy findings available pletion of cause of                |
| Vita                       | Physician: The this certificate al director, pag   | Be                            | 25. Was case referred to medical examiner?  1  Yes 2 No Hospita   | al: 1 Alpatient 2 1  | ED/Outpations                   | 2[] DOA   O#  | ner.  | th (Check only o                                 |                                  | h (C (   |  |
| Division of Vital Records, | 9 9  | atlon: To                     | 27. Magner of Death 1 Naturat 5 Pending 2 Accident investigation  | a. Date Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury          | 28c. Inju   | 4   Nursing n                                       | ome 5 Resid                                      |                                  |  |  |
| Divis                      | tal or Att   | Certification:                | 3 Suicide 6 Could not be determined 280   | e. Ptace of Injury - At ho<br>building, etc. (Specify  | me, farm, stre                  | et, factory, office   |   | 28f. Location (S<br>City or Tow                  |                                  | ber or Aural   | Route Number,  |
|                            | To the Hospital or Attendity within 24 hours after death.  To the Funeral Director: A second pletely filled in by the funeral or the funeral process.  | Medical                       | 29a. Certifier 1 Certifying Physician 2 Medical Examiner: 0 a   | : To the best of my know<br>the basis of examinat<br>and manner stated.  | wledge, death<br>ion and/or inv | occurred at the trestigation, in my o                                 | me, date and ptace<br>opinion, death occu           | , and due to the or<br>rred at the time, o       | cause(s) and n<br>date and place | nanner as sta<br>, and due to                              | ited.<br>the cause(s)                                    |
|                            | 7.0  | Σ                             | 29b. Signature apet title of certifier  | 15   | MD                              | 29c. Licens   | t467  | -  | 29d. Date sign                   | ed (Month, E   | ay, Year)  |
| -                          | L  |                               | 30. Name and address of person who complete Rebeica Bark  | er 99  | 101                             | Print) Pedi   | cal Co  | nter   | DR,                              | Rock   | ville MD   |
|                            | Sta<br>Regist  |                               | 31. Date filed (Month, Day, Year)  JUL 0 5 2006   | 32 Registrar's Signat  | ture App                        | de  |   |  | /                                | 2  | 0850   |

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

|  | 1<br><u>R</u>                       | Registrar Amend #10c, 10e, 10f per print player logate 11-2006 CNM Reg No. 2006 225  |                   |              |              |          |              |   |
|--|-------------------------------------|--|-------------------|--------------|--------------|----------|--------------|---|
| Physician<br>ledical Examina   |                                     | SHORON DENISE AndLASON  2. Date of Death Month Day July 3, 2006  3 Time of Death 1541 hrs  |                   |              |              |          |              |   |
|  | •                                   | 4a Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death 4c County of Death University Hospital 4d County of Death 4d County of Death   |                   |              |              |          |              |   |
| Funeral<br>Director  | - 1                                 | 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 344777000000000000000000000000000000000  |                   |              |              |          |              |   |
| 215-0036 be filed within 72 hours after death with the Maryland mal Hygiene riked other than "natural", or items 23a or 28a-f show any vent, the Medical Examiner must be notified at once.  | To Be Completed by Funeral Director | Usual Residence of Decedent  10 State 10b. County 11   |                   |              |              |          |              |   |
| Physician<br>/Medical<br>Examiner  | er                                  | 23a. Part I Ent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause.   |                   |              |              |          |              |   |
| 760,<br>icate be executed<br>physician and<br>the burial - transit   | /Medical Exa                        | hysician/Medical Exa   | Physician/Medical | /Medical Exa | /Medical Exa | /Medical | /Medical Exa | (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  UNPENDED  AMENDED  FFEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown  Part II. Other significant conditions  contributing to death but not resulting in the underlying cause given in Part I.  23d. Date of delivery  Month Day Year  23d. Date of delivery  Month Day Year  23d. Date of delivery  Month Day Year  23d. Date of delivery  23d. Date of delivery  Month Day Year  23d. Date of delivery  23d. Date of delivery  23d. Date of delivery  23d. Date of delivery  Month Day Year |
| P.C  | Completed by                        | 1 Yes 2 No 3 Probably 4 Unknown  24a Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25 Was case referred to medical 26 Place of Death (Check only one)  |                   |              |              |          |              |   |
| Division of Vital Records, ra or Attending Physician: The law require rs after death.  The Director: After this certificate has been similar by the funeral director, page 2 should be in by the funeral director, page 2 should be a second to be a s | To Be                               | examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other,4 Nursing Home 5 Residence 6 Other:  27. Manner of Death  1 Natural 5 Pending 2 V Accident  Investigation  1 Inpatient 2 V ER/Outpatient 3 DOA  Other,4 Nursing Home 5 Residence 6 Other:  28b. Time of Injury 1 Yes 2 No  1 Yes 2 No  Other,4 Nursing Home 5 Residence 6 Other:  28d. Describe how injury occurred Passenger auto collision |                   |              |              |          |              |   |
| Divisi<br>Hospital or At<br>24 hours after d<br>Funeral Direct   | al Certification:                   | 3 Suicide 6 Could not be determined 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Queenstown Road & Amos Drive, Severn, MD  |                   |              |              |          |              |   |
| To the Hos<br>within 24 h<br>To the Fun<br>completely  | Medical                             | 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  29b Signature and title of certifier  29c License number  29d Date signed (Month, Day, Year)  July 4, 2006   |                   |              |              |          |              |   |
| 5  |                                     | 30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  |                   |              |              |          |              |   |
| Sta  |                                     |  |                   |              |              |          |              |   |
| Regist  DHMH 17 Rev 1/20   |                                     | ORIGINAL ORIGINAL  |                   |              |              |          |              |   |

|            |  |                   | 1 = For<br>State<br>Registrar   | State of Mar  |                        | artment of rtificate of              |   | l Mental Hy                               | giene<br>Reg. No.2006                             | 22532                             |  |
|------------|--|-------------------|---|---|------------------------|--------------------------------------|---|---|---|-----------------------------------|--|
|            | Physici  | an                | 1. Decedent's Name (First, Middle, Last)  |   |                        |                                      |   | July 9                                    |   | 3. Time of Death                  |  |
|            | /Media   |                   | JUDITH ELAINE   |   | · <del></del>          |                                      |   |   |   | 9:55am м                          |  |
| 7          | Examir   | ner               | 4a. Facility Name (If not institution, give s<br>Civista Medical C  |   |                        | LaPlata                              | or Location of De                       | ath                                       | 4c. County of Dea                                 |                                   |  |
| - 2° M     | Funeral  |                   | 5. Social Security Number 6. Sex  |   | In yrs. last birthday) | If Under 1 Yea                       | r If Under 24 H                         |   |   | thplace (State or Foreign ountry) |  |
|            | Director   |                   | 214-74-9206   | M 2(X)F   | 1 Yrs.                 | Months Days                          | Hours Mi                                | n. (Month, Da<br>MAR • 2                  | 7,1955 WA   | SH., D.C.                         |  |
|            | P > 2  |                   | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location   |   |                        |                                      |   |   |   | 10d. Inside City Limits           |  |
|            | Aaryla<br>r eho  | ō                 | MARYLAND CHARI  |   |                        | N HEAD                               |   |   |   | 1XXes 2 □ No                      |  |
|            | 28a-   | rect              | 10e. Street and Number  |   |                        | 10f. Zip Code                        |   |   | 10g. Citizen of What Co                           | ountry?                           |  |
|            | h with   | Funeral Director  | 3 PINE STREET   |   |                        | 206                                  | 540                                     |   | U.S.A.  |                                   |  |
|            | deat   | ner               | 11. Marital Status  | 12. Was Decedent Eve<br>Armed Forces?                           | er in U.S. 13.         | Was Decedent of                      | Hispanic Origin?                        | (Specify Yes or No<br>erto Rican, etc.)   | 14. Race - Ame<br>Black, Whit                     |                                   |  |
| 98         | or ite   | by Fu             | 1 Never Married 2 Married   | Armed Forces? 1 ☐ Yes 2 No If Yes, Give                         |                        | 1□Yes 2☐XN                           |   | ,   |   | HITE                              |  |
| 21215-0036 | 72 hours after death with the Maryland<br>natural; or items 23a or 28a-f ehow<br>dical Examiner must be notified at  | q pa              | 3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ   | Year or Dates:  | 16a Dece               | dent's Usual Occu                    | ination                                 |   | 16b. Kind of Business                             |                                   |  |
| 15         | n "na  | Completed         | (Specify only highest grade   | completed)  | (Give                  | kind of work done DO NOT use retir   | e during most of w<br>ed)               | vorking                                   | TOD. IXITY OF BUSINESS                            | villadistry                       |  |
| 212        | filed within Hygiene.  | E                 | 12  | College (1-4or 5+)  |                        | PERVISO                              | )R                                      |   | UNITED B  | ANK & TRUS                        |  |
| p          | al Hygie<br>d other  | Be                | 17. Father's Name (First, Middle, Last)   |   |                        |                                      |   |   | , Maiden Surname)                                 |                                   |  |
| yla        | should be<br>nd Mental<br>smarked o  | ဥ                 | BENARD EDWARD W   |   |                        |                                      |   |   | INIA BRYA   |                                   |  |
| Maryland   | ~ @ = =  |                   | 19a. Informant's Name/Relationship (Type<br>WILLIAMS ADAMS-   |   |                        | _                                    |   |   | er, City or Town, State, .<br>AD , MARYLAI        |                                   |  |
| σĵ         | s 1 and 2<br>f Health<br>item 27<br>other tr   | Ш                 | 20a. Method of Disposition  | повышь  | 20b. Place of Dispo    | sition (Name of                      | 1                                       | Date                                      | 20c. Location - City or                           |                                   |  |
| Baltimore, | Pages<br>ent of<br>nt: # if<br>ry or o   |                   | 1 ☐ Burial 2 ☑ Cremation 3 ☐ Ro<br>4 ☐ Donation 5 ☐ Other (Specify)   | emoval from State<br>M 단구되                                      | •                      | matory or other pl                   | ATORY 7-14-06 ALEXANDRIA, VA            |   |   |                                   |  |
| a<br>E     | permit. Pages Department of h<br>Important: if ite<br>eny injury or of<br>once.  | 1                 | 21. Signature of Freeral Service License  |   | 0479 2                 | Name and Add                         | ress of Facility                        |   |   | 2.71 / V.11                       |  |
| m          | Depa<br>Impo<br>eny ii   |                   | Mulul   | 150   |                        |                                      |   |   | ICE, P.A.   |                                   |  |
|            |  |                   | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on  | cations that caused the cause on each line.                     | e death. Do not en     | ter the mode of dy                   | ing, such as card                       | iac or respiratory a                      | irrest,   | Approximate<br>Interval Between   |  |
|            | Physician  |                   | Immediate Cause (Final disease or condition resulting in death)   | Card  | in Resp                | ratory                               | Arre                                    | 258                                       | -4:   | Onset and Death                   |  |
|            | /Medical<br>Examiner   |                   | resulting in death)   | Due to or as a d  | consequence of):       | 000                                  | Ho                                      | Metas                                     | Luci -  |                                   |  |
| 车家         |  | - G               | Sequentially list conditions, if any, leading to immediate  |   | consequence of):       | CH                                   | W/V1                                    | menas                                     | rasus   |                                   |  |
| Z          | uted<br>d<br>ansit   | Examiner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |   |                        |                                      |   |   |   |                                   |  |
| o,         | exec<br>en an  |                   | resulting in death) Last  | Due to (or as a   | consequence of):       |                                      |   |   | 7   | -                                 |  |
| 8760,      | The law requires that the death certificate be executed the law seen signed by the attending physicien and page 2 should be detached for use as the burial-transit | Physician/Medical | <b>€</b> d  |   |                        |                                      |   |   |   |                                   |  |
| 39 >       | leath certifica<br>attending ph<br>i for use as th   | Med               | IF FEMALE:  |   |                        |                                      |   |   |   |                                   |  |
| Вох        | attend<br>for us   | lan/              | in the past 12 months?  | 3c. If yes, outcome of<br>1□Live birth 2  <br>4□Pregnant at tin | Fetal death 3          | Ectopic pregnan                      | су                                      |   | 23d. Date of de<br>Month                          | livery<br>Day Year                |  |
| o.         | that the de<br>ned by the a  | ysic              | 1 ☐ Yes 2 ♥ No<br>9 ☐ Unknown   | 9☐ Unknown  | ne or death 5L         | Other (specify)                      |   |   |   |                                   |  |
| ٥.         | res that I<br>igned by<br>be deta  |                   | Part II. Other significant conditions con   | tributing to death but  | not resulting in the u | inderlying cause g                   | iven in Part I.                         | 23e. Did 1                                | tobacco use contribute to                         | the cause of death?               |  |
| rds        | w requires<br>been sign<br>should be   | ed by             | JEE!  | PVEIN   | THRO                   | mpo                                  | 212                                     | 1 🗆                                       | Yes 2 No 3 P                                      | robably 4 Unknown                 |  |
| 00         | aw red   | plete             | AN  | EMIA  | -                      | ,                                    |   | 24a. Was                                  | an 24b. Were au                                   | utopsy findings available         |  |
| R          |  | Completed         | 56  | -TZUF   | 3/= 90                 | ME                                   | Tr                                      |   | prior to death?                                   | completion of cause of            |  |
| /ita       | Physician: Th<br>r this certificate<br>ral director, pag   | Be                | 25. Was case referred to medical examiner?  | # = O V   |                        |                                      | 26. Place of D                          | eath (Check only                          |   |                                   |  |
| of Vital   | Physic<br>rthis corral dire  | 2                 | 1 ☐ Yes 2 ☐ No H  | ospital:  | 2 ER/Outpatier         | IL SEL DON                           |   |   | dence 6 Other (Spe                                | icify)                            |  |
|            | ding<br>After<br>fune  | lon:              | 27. Manner of Death  1 Natural 5 Pending  | 28a. Date of Injury<br>(Month, Day Y                            | 'ear) 28b. Time o      | W                                    | uryat<br>ork?<br>⊒Yes 2 ⊒No             | 28d. Describe                             | 28d. Describe how injury occurred                 |                                   |  |
| Division   | Attending in death. ector: After by the fune   | licat             | 2 Accident Investigation 3 Suicide 6 Could not be   | 28e. Place of Injury  | - At home, farm, st    |                                      |   | 28I. Location (                           | Street and Number or Ri                           | ural Route Number                 |  |
| Ω          | after after Dire   | Certification:    | 4 Homicide determined   | building, etc.  | (Specify)              |                                      |   | City or To                                |   |                                   |  |
|            | To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer  | edical C          | 29a. Certifier (Check only one)   | er: On the basis of e   | kamination and/or in   | h occurred at the vestigation, in my | time, date and pla<br>opinion, death oc | ce, and due to the<br>curred at the time, | cause(s) and manner as<br>date and place, and due | s stated.<br>e to the cause(s)    |  |
|            | ithin a  | Med               | 29b. Signature and title of gertifier   | and manner state  | u.                     | 29c. Licer                           | nse number                              |   | 29d. Date signed (Mont                            | h, Day, Year)                     |  |
|            | ⊢≯⊢ŏ   |                   | Aller (C  | man.  |                        | 5770                                 |   |   | 1   | 06                                |  |
|            | di   |                   | 30. Name and address of person who co   | mpleted cause of dea  | th (Item 23a) (Type,   | Print)                               |   |   |   |                                   |  |
| 12         | Sta  | ata               | Abbas A. Omais, M   | U, Cenna Me<br>Registrar's                                      | dical Ctr              | .,/-C Po                             | st Offic                                | e RD., Wa                                 | aldorf,MD 20                                      | 0602                              |  |
|            | Regist   |                   | 201 I 0 5000  | The same  | 20 1                   |                                      |   |   |   |                                   |  |

Judith F

Adams.

|  |  | 1                               | For State Registrar   | State of Ma   |                      | / Depa                       | ırtme          |   | ealth and   | d Menta                | Reg                                 | 200                             | 6                       | 225                               | 33                   |      |
|--|--|---------------------------------|---|---|----------------------|------------------------------|----------------|---|---|------------------------|-------------------------------------|---------------------------------|-------------------------|-----------------------------------|----------------------|------|
|  |  |                                 | 1. Decedent's Name (First, Middle, Last)  |   |                      |                              |                |   |   | 2. Date                | e of Death                          | Day                             | Year                    | 3. Time of I                      | Death                |      |
|  | ysicia<br>/ledic                                   |                                 | Robert L  | ayton   | Armstrong            |                              | Sr.            |   |   |                        | ne 27                               |                                 |                         | 1449                              | M                    |      |
|  | amine  |                                 | 4a. Facility Name (If not institution, give   | street and number)  |                      |                              | 4b. City       | , Town, or                                | Location of De  | ath                    |                                     | 4c. County o                    | f Death                 |                                   |                      |      |
|  |  | 76                              | PENINSULA REGIONAL  | MEDICAL   | CENTE                | 3                            |                | ALISB                                     |   |                        |                                     | WICO                            |                         |                                   |                      |      |
| Fun<br>Dire  |  |                                 | 417-44-7484   | 7. Ago<br>M 2□F   | e (In yrs. las<br>70 | t birthday)<br>Yrs.          | If Undo        | Days                                      | Hours M   | in. 8. Date (Mo<br>3/2 | e of Birth<br>nth, Day, Y<br>20/193 | (ear)<br>36                     | 9. Birth<br>Cou<br>Alak | place (State or<br>ntry)<br>Dama  | Foreign              |      |
| pug *  | 223  | -                               | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City,           | Town or Lo                   | cation         |   |   |                        |                                     |                                 |                         | 10d. Inside City                  | y Limits             |      |
| lary!  | 20   | 5                               | Maryland Wicomic  | 0   | Sa                   | lisbu                        | rv             |   |   |                        |                                     |                                 |                         | <b>X</b> □ Yes                    | 2 🗌 No               |      |
| the A  | 9  | ect                             | 10e, Street and Number  |   |                      |                              |                | ip Code                                   |   |                        | 10g                                 | . Citizen of W                  | hat Cou                 | intry?                            |                      |      |
| with se or   | 4  | <u>ā</u>                        | 205 Locust Street   |   |                      |                              |                | 2180                                      | 4   |                        |                                     | USA                             |                         |                                   |                      |      |
| Jeath<br>ne 23   | ST I   | Funeral Director                | 11. Marital Status  | 12. Was Decedent  |                      | 13.                          | Nas Dec        | edent of His                              | spanic Origin?<br>n, Mexican, Pu  | (Specify Ye            | s or No-                            |                                 |                         | ican Indian,                      | -                    |      |
| urs after o  | Minima   | by Fur                          | 1 Never Married 2 Married 3 Widowed 4 Divorced  | Armed Forces?  1 Yes 2 1 1  If Yes, Give Year or Dates:                 |                      | 1                            |                | **  | Specify:  | ieno Hican, i          | etc.)                               | Specify:                        | , White,<br>Wh          | nite                              |                      |      |
| pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene.  Maportent: If team 27 is marked other than "natural", or Iteme 23s or 28s-f show | Audical E  | Completed                       | 15. Decedent's Edu<br>(Specify only highest grad  | e completed)  |                      | 16a. Deced<br>(Give<br>life. | kind of w      | ual Occupa<br>rork done d<br>use retired; | uring most of v   | working                | 16                                  | b. Kind of Bus                  | iness/Ir                | ndustry                           |                      |      |
| within<br>iene.  | De.  | E O                             | Elementary/Secondary (0-12)   | College (1-4or 5  | 0+)                  | Di                           | spat           | cher                                      |   |                        |                                     | Shore                           | Tra                     | nsit_                             |                      |      |
| filed<br>Hygie   | event,   | BeC                             | 17. Father's Name (First, Middle, Last)   |   |                      |                              |                |   | 18. Mother's N  | Name (First,           | Middle, Ma                          | iden Sumame                     | )                       |                                   |                      |      |
| hould be<br>d Mental   | •  | 0 8                             | Robert Richard Ar   | mstrong   |                      |                              |                |   | Marth   | na Ros                 | e Lay                               | ton                             |                         |                                   |                      |      |
| 2 should<br>and Men<br>ie marke  | 20   |                                 | 19a. Informant's Name/Relationship (T)  |   |                      |                              |                |   | nd Number or<br>h St.,  |                        |                                     | -                               | State, Zij              | p Code)                           |                      |      |
| 1 and<br>Health  | `= .   |                                 | Brandy E. Armstro   | ng/daugnt   |                      |                              |                |   |   | Date                   |                                     | ic. Location - 0                | ite or T                | oun State                         |                      |      |
| ges 1<br>t of H  | ~  |                                 | 20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F   | Removal from State  | i                    | ce of Dispo<br>netery, crer  |                |   |   |                        |                                     |                                 | -                       |                                   |                      |      |
| Pages<br>ment of<br>ent: If It   | nu   |                                 | * 4 ☐ Donation 5 ☐ Other (Specify)  |   | Sali                 | .sbury                       |                |   |   | 28/06                  | _                                   | Salisbu                         |                         |                                   |                      |      |
| permit. Pag<br>Department<br>Importent:  | any injury o                                       |                                 | 23a. Part1. Enter the disease, or compshock, or heart failure. List only o  | ODDIO CI  | FSP                  | 5                            | 01 S           | now H                                     | ill Rd.   | ., Sal                 | isbur                               | y, MD 2                         | As<br>2180              | sociat:<br>4                      | ion                  |      |
| /Med<br>Exam   | lical  | d by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as  Due to (or as  Due to (or as                             | a conseque           | nce of):                     | 7/0            | α <b>ν</b>                                | disc  | 95c                    |                                     |                                 |                         |                                   |                      |      |
| ath certificate  | detached for use as the buria                      |                                 | cai   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | d                    | of pregnance                 | cy<br>leath 3[ | ⊒Ectopic<br>⊒ Other (                     | pregnancy<br>specify)   |                        |                                     |                                 | 23d. Date<br>Mon        |                                   | ,                    | /ear |
| uires that   | 2  |                                 | Part II. Other significant conditions co  | ntributing to death b   | out not result       | ing in the u                 | nderlying      | cause give                                | en in Part I.   | 23                     |                                     |                                 |                         | the cause of debably 4 📉          |                      |      |
| Physician: The law requires t  | age 2 should                                       | Completed                       |   |   |                      |                              |                |   |   | -                      | a. Was an autopsy performe          | ed? d                           | nor to co               | copsy findings a completion of ca | available<br>ause of |      |
| ician: Th  | or, p  |                                 | 25. Was case referred to medical  |   |                      |                              |                |   | 26. Place of  |                        |                                     | -                               |                         |                                   |                      |      |
| Physician:   | lirect   | To Be                           | avaminar?   | Hospital:   | ent 2 E              | R/Outpatie                   | nt 3 🗆 l       | Othe                                      | 200   |                        |                                     | ce 6 Othe                       | r (Spec                 | ity)                              |                      |      |
| iding Phys   | funeral  |                                 | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation   | 28a. Date of Inju<br>(Month, Da   | ury 2                | 28b. Time o<br>Injury        |                | 28c. Injury<br>Work                       | / at<br>⟨?<br>Yes 2 □ No  | 28d. De                | escribe how                         | injury occurre                  | ed                      | ,                                 |                      |      |
| after death.   | d in by the  | Certification;                  | 3 Suicide 6 Could not be<br>4 Homicide determined   |   |                      |                              |                | 28f. Lo                                   | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |                        |                                     |                                 |                         |                                   |                      |      |
| To the Hospital or Attending within 24 hours after death. To the Funeral Director: After   | completely filled in by the funeral director, page | Medical C                       | 29a. Certifier 1X Certifying Phy<br>(Check only 2 Medical Examone)  | vsician: To the best<br>iner: On the basis of<br>and manner st          | of examination       | ledge, deat<br>on and/or in  | th occurre     | ed at the time<br>on, in my o             | ne, date and pl<br>pinion, death o  | lace, and du           | e to the cau<br>ne time, dat        | se(s) and mar<br>e and place, a | nner as<br>nd due       | stated.<br>to the cause(s)        | )                    |      |
| o the  | отр  | Me                              | 29b. Signature and title of certifier   | . /   |                      |                              | 2              | 9c. License                               |   |                        | 290                                 | d. Date signed                  | (Month                  | , Day, Year)                      |                      |      |
| - 31   | - 0  |                                 | > PM  | rul   |                      |                              |                | D5  | 1480'   | 7                      |                                     | 10-                             | 29-                     | 06                                |                      |      |
| ind  | 0  |                                 | 30. Name and address of person who  |   |                      |                              |                |   |   |                        |                                     |                                 | -/                      |                                   |                      |      |
| 111  |  |                                 | RAMESH AGAR   | WAL, M.D.   | 145                  | 5 E. C                       | acr            | 011 St                                    | . SA  | LISBU                  | RY                                  | MD.                             |                         |                                   |                      |      |
| R  | Sta<br>egisti                                      |                                 | RAMESH AGAR.  31. Date filed (Month) Pay, Year)   | 006 32. <b>Reg</b> ist  | rar's Signatu        | ire                          | book           |   |   |                        | 17                                  |                                 |                         |                                   |                      |      |

DHMH 17 Rev 1/2001

|                            |  |                | For<br>State<br>Registrer  | State of M  | laryland /         | •  | artment of Heal<br>crtificate of Dea                                      |   | ental Hygiei                                     | 400                                      | 6 22531   |  |  |
|----------------------------|--|----------------|--|---|--------------------|--|---|---|--|--|---|--|--|
|                            | Obvestati  |                | 1. Decedent's Name (First, Middle  | e, Last)  |                    |  |   |   | 2. Date of Death Month                           | Day Year                                 | 3. Time of Death                                    |  |  |
|                            | Physici:<br>/Medic   |                | LEONARD DALE ADKINS, SR. June  |   |                    |  |   |   |  | 6 200                                    | 6 23:02   |  |  |
| )                          | Examin   | er             | 7  | DNN Medica  | n Co               | Wills  | //  | usky  |  | 4c. County of De                         | mics  |  |  |
|                            | Funeral<br>Director  |                | 5. Social Security Number 217-30-9819  | 6. Sex 7. A   | ge (In yrs. last I | yrs.   |   | nder 24 Hrs.<br>urs Min.                      | 8. Date of Birth<br>(Month, Day, Ye<br>09-04-193 | ar) (                                    | irthplace (State or Foreign<br>Country)<br>YLAND    |  |  |
| land                       | land<br>wo   | }              | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, To      | own or Lo                                    | cation  |   |  |  | 10d. fnside City Limits                             |  |  |
|                            | Many<br>a-f sh   | tor            | MD WI  | COMICO  | PARSON             | NSBUI  | RG  |   |  |  | 1 ☐ Yes 2X No                                       |  |  |
| ath with the               | th the   | Director       | 10e. Street and Number   |   |                    |  | 10f. Zip Code   |   | 10g.   | Citizen of What C                        | Country?  |  |  |
|                            | ath wi   |                | 7570 JONES HAS   |   |                    |  | 21849   |   |  | USA                                      |   |  |  |
| 36                         | s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examinal must be notified at | by Funeral     | 11. Marital Status  1 ☐ Never Married 2 ☒ Mar  3 ☐ Widowed 4 ☐ Divorced  | If Yes Give   | ?<br>1054-         |  | Was Decedent of Hispani<br>If Yes, specify Cuban, Me<br>1 ☐ Yes 2☐ No Spe | ic Origin? (Spe<br>exican, Puerto I<br>ecity: | cify Yes or No-<br>Rican, etc.)                  | 14. Race - Am<br>Black, Wh<br>Specify:   |   |  |  |
| Š                          | 2 hou  |                |  | it's Education  | 16                 | Sa. Dece                                     | dent's Usual Occupation   | most of works                                 | 16b  | . Kind of Busines                        |   |  |  |
| 21215-003                  | thin 7   | Completed      | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)   |   |                    |  |   |   |  |  | OLITE GOLD LAND                                     |  |  |
|                            | filed wi<br>Hygien<br>Sther th   | S              | 9  | (   |                    | ]  | ELECTRICIAN   | dathada Nasa                                  |  | WER COMP                                 | 'ANY  |  |  |
| and                        | d be fi  | Be             | 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden  19. Mother's Name (First, Middle, Maiden  19. Mother's Name (First, Middle, Maiden) |   |                    |  |   |   |  |  |   |  |  |
| aryland                    | 2 should be I<br>and Mental I<br>is marked o<br>aumatic eve  | ၉              | 19a. Informant's Name/Relations  |   | 1:                 | 9b. Mailir                                   | ng Address (Street and N  |   |  |  | , Zip Code)   |  |  |
| Σ                          | 1 and 2 :<br>Health ar<br>tem 27 is  |                | DIANE ADKINS -   | SPOUSE  |                    | 7570   | JONES HAST  | INGS RO                                       | AD, PARSO  | NSBURG,                                  | MD. 21849   |  |  |
| altimore,                  | es 1 a<br>of Hea<br>f Item<br>r othe   |                | 20a. Method of Disposition   | 2 Demond from State   | ceme               |  | sition (Name of<br>matory or other place)                                 | D   | ate 20c  | Location - City of                       | r Town, State                                       |  |  |
| Ē                          | Peges<br>ment of<br>ant: If It<br>ury or o   |                | 1 X Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (S  |   |                    | ICO I  | MEM. PARK   | 06-30   | -2006 SA   | LISBURY,                                 | , MARYLAND  |  |  |
| Balt                       | permit. Peges<br>Department of<br>Important: If if<br>any Injury or o  |                | 21. Signature of Funeral Service   | Licensée Bla  | to                 |  | 2. Name and Address of F  |   |  |  |   |  |  |
|                            |  |                | 23a. Part1. Enter the disease, o shock, or heart failure. List   |   |                    |  |   | ch as cardiac o                               | r respiratory arrest,                            |  | Approximate<br>Interval Between<br>Onset and Death  |  |  |
| 1                          | Pnysician  | i V            | Immediate Cause (Finaf disease or condition resulting in death)  a. LARGE 13-Cell LymphomA  Onset and Death  |   |                    |  |   |   |  |  |   |  |  |
|                            | /Medical<br>Examiner   |                | Due to (or as incrinsequence of):  |   |                    |  |   |   |  |  |   |  |  |
|                            | 100  | ē              | Secuentially list conditions if any, leading to immediate  | b. Due to (or as  | s a consequenc     | ce of):                                      |   |   |  |  |   |  |  |
|                            | cuted  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events   |   |                    |  |   |   |  |  |   |  |  |
| o,                         | e exec<br>ien ar<br>ırial-tı   |                | resulting in death) Last   | Due to (or as   | s a consequenc     | ce of):                                      |   |   |  |  |   |  |  |
| 8760                       | cate be executed<br>physicien and<br>the burial-transit  | dicai          |  | d   |                    |  |   |   |  |  |   |  |  |
| 9                          |  | /Me            | IF FEMALE:   | 23c. If yes, outcome  | e of pregnancy     |  |   |   |  | 23d. Date of de                          | -15   |  |  |
| P.O. Box                   | The law requires that the death certify we has been signed by the attending age 2 should be detached for use as  | Physician/Me   | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | In the past 12 months?  1 Yes 2 No  1 Yes 2 No                      |                    |  |   |   |  |  | Month Day Year                                      |  |  |
|                            | w requires that<br>been signed t<br>should be deta   | þ              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacc                                |   |                    |  |   |   |  | co use contribute to the cause of death? |   |  |  |
| Division of Vital Records, | hysician: The law re<br>his certificete has bei<br>I director, page 2 sho  | Completed      |  |   |                    |  |   |   | 24a. Was an autopsy performed 1 Yes 2            | prior to<br>death?                       | autopsy findings available occumpletion of cause of |  |  |
| ita                        | Attending Physician: or death. ector: After this certifice by the funeral director.  | Be             | 25. Was case referred to medica examiner?  | ıt  |                    |  |   | Place of Death                                | (Check only one)                                 |  |   |  |  |
| <u>&gt;</u>                | Physic<br>this co  | မ              | 1 ☐ Yes 2 🗙 No   | Hospital: Inpat   |                    |  |   |   | ne 5 Residence                                   |  | ecify)  |  |  |
| 0 5                        | ling P   | ion:           | 27. Manner of Death  1 Natural 5 ☐ Pendi   |   | lay Year) 28t      | 28b. Time of Injury at Work?  M 1 1 Yes 2 No |   |   |  |  |   |  |  |
| S                          | death<br>ctor:<br>y the  | ficat          | 3 ☐ Suicide 6 ☐ Could  |   | niury - At home.   | farm. str                                    | M 1 ☐ Yes   |   | 28f. Location (Street                            | and Number or F                          | Rural Route Number,                                 |  |  |
| <u> </u>                   | after<br>after<br>1 Dire<br>d in b   | Certification: | 4 Homicide determ  | building, e   | etc. (Specify)     |  |   |   | City or Town, Si                                 | ate)                                     |   |  |  |
|                            | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>Completely filled in by the funeral  | edicai C       | 29a. Certifier (Check only one) Certifyi   | ng Physician: To the best<br>Examiner: On the basis<br>and manner s | of examination     | dge, death<br>and/or in                      | h occurred at the time da<br>vestigation, in my opinion                   | ite and these as, death occurre               | and due to the nause<br>ad at the time, date     | (s) and mannar :<br>and place, and du    | as stated<br>ue to the cause(s)                     |  |  |
|                            | Within To the Comp   | ž              | 29b. Signature and title of certifie   | er<br>1 /   |                    |  | 29c. License num  |   |  | Date signed (Mor                         |   |  |  |
| )                          | 108  |                | <b>)</b> J. O  | Anlen   |                    | 7  | D2-   | 728   | 3  | 6/2                                      | 9/2006  |  |  |
| 4                          | 792/V  |                |  | who completed cause of  | death (Item 23:    | a) (Type,                                    | Print) STREET   |   |  | 21801                                    | ,   |  |  |
|                            | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year   | 32. Regge<br>3 0 2006   | trar's Signature   | K.   | Small   | -   | / /  |  |   |  |  |
| 17                         | negisti  | al             | JUIN S   | ) O 5000 100  | WAR A              | 1  |   |   |  |  |   |  |  |

|             |  |              | For<br>State<br>Registrar  | State of N   |   | artment of Healt<br>rtificate of Dea  |  | I Hygien<br>Reg. N                  | 4000  | 22535                                  |  |  |
|-------------|--|--------------|--|--|---|---|--|-------------------------------------|---|--|--|--|
|             |  |              | 1. Decedent's Name (First, Middle, La  | ist)   |   |   |  | e of Death                          | av - Year                                       | 3. Time of Death                       |  |  |
|             | Physicia<br>/Medic   | al           | Ethel E. Alexander   |  |   |   | Jul  |                                     | 9° 2006 9:00 A M                                |  |  |  |
|             | Examin   |              | 19508 Lorraine Terrace   |  |   |   | on of Death                                  |                                     | c. County of Death<br>Washir                    | ngton                                  |  |  |
|             | Funeral<br>Director  |              |  | Sex 7.7<br>1 M 2 □ XF  | Age ( <i>In yr</i> s. last birthday)<br>81 yrs.       | If Under 1 Year If Un<br>Months Days Hou                                      | rs Min. 8. Date (Mo. Ma.                     | of Birth<br>nth, Day, Yea<br>r 23 1 | 9. Birth<br>925 E                               | place (State or Foreign<br>ntry)<br>PA |  |  |
|             | pur *  |              | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, Town or L                                  | ocation   |  |                                     |   | 10d. Inside City Limits                |  |  |
|             | Manyli<br>f sho  | ō            |  | ington   | Hage  | rstown  |  |                                     |   | 1 ☐ Yes 2 X No                         |  |  |
|             | with the I<br>te or 28e-<br>Le rotif   | Director     | 10e. Street and Number<br>19508 Lorraine   |  |   | 10f. Zip Code 217   | 742  | 10g. C                              | Citizen of What Cou                             | ntry?<br>JSA                           |  |  |
| 36          | ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23e or 28e-f show or other traumatic event, the Medical Exam, at must be rediffed at | by Funeral   | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | 12. Was Decede<br>Armed Force<br>1  Yes 2<br>If Yes, Give<br>Year or Dates | XI No   | Was Decedent of Hispanic<br>If Yes, specify Cuban, Mex<br>1 ☐ Yes 2 ☑ No Spec | Origin? (Specify Ye<br>ican, Puerto Rican, e | s or No-<br>etc.)                   | 14. Race - Ameri<br>Black, White,<br>Specify: W |  |  |  |
| 5-0036      | 2 hou  | ted          | 15. Decedent's E   |  | 16a. Dece   | dent's Usual Occupation   | most of working                              | 16b.                                | Kind of Business/Ir                             | ndustry                                |  |  |
| 21215       | 12 should be filed within 7<br>h and Mental Hygiene.<br>7 is marked other than "n<br>raumatic event, the Med   | Completed    | (Specify only highest given the state of the | College (1-4c  | life.   | Secretary   | most of working                              | Ca                                  | ounty gov                                       | ermnent                                |  |  |
|             | e filec<br>al Hyg<br>I othe<br>vent,   | Be C         | 17. Father's Name (First, Middle, Las  |  |   | 18. M   | other's Name (First,                         | Middle, Maide                       | en Sumame)                                      |  |  |  |
| Maryland    | Ments<br>Ments<br>arked  | 2            | John Franklin  |  |   |   | argaret G                                    |                                     |   |  |  |  |
| Nar         | 12 sho<br>n and<br>r is m<br>raum  | 1            | 19a. Informant's Name/Relationship   | •  |   | ng Address (Street and Nu   |  |                                     |   |  |  |  |
| -           | 1 and<br>Health<br>em 27<br>ither tr   | 1 16         | Arthur M. Alexan   | der spo  | 20b. Place of Disp                                    | 08 Lorraine   | Terrace,                                     | lagers<br>20c.                      | Location - City or T                            | own, State                             |  |  |
| nor         | Pages<br>nent of h<br>int: If ite  |              | 1 Burial 2 Toremation 3  |  | te !  | matory or other place)<br>nd Valley Cr  | .em. 7/13/∩                                  | 6 Way                               | mashoro   | DA 17268                               |  |  |
| Baltimore   | permit. Pages 1 and 3<br>Department of Health<br>Important: If item 27<br>any injury or other tr.<br><u>once</u> .   |              | Cumberland Valley Crem 7/13/06 Waynesboro, PA 17268  21. Signature of Funeral Service Licensee    Cumberland Valley Crem 7/13/06   Waynesboro, PA 17268   |  |   |   |  |                                     |   |  |  |  |
|             |  |              | 23a Part I Forer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate   |  |   |   |  |                                     |   |  |  |  |
|             | Physician<br>/Medical<br>Examiner  |              | shock, for hear failure. List onf<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)   | 1 B  | as a conseque   | Loud  | cunc   | v.                                  |   | Interval Between<br>Onset and Death    |  |  |
|             |  | ner          | Sequentially list conditions, if any, leading to immediate saws. Enter or denying Cause (Disease or injury   | b. Due to (or  | as a consequence of):                                 |   |  |                                     |   |  |  |  |
|             | ate be executed obysician and the burial-transit   | Examiner     | Cause (Disease or injury that initiated events c.  resulting in death) Last Due to (or as a consequence of):   |  |   |   |  |                                     |   |  |  |  |
| 8760,       | ate be ex<br>physician<br>the buria  | dical E      | •  | d  |   |   |  |                                     |   |  |  |  |
| 9           |  | Med          | IF FEMALE:   |  |   |   |  |                                     |   |  |  |  |
| O. Box      | the death certific<br>y the attending p  | Physician/Me | 23c. If yes, outcome of pregnancy in the past 12 months? 1   |  |   |   |  | 23d. Date of delivery  Month Day Yo |   |  |  |  |
| م           | s that<br>gned b   | by           | Part II. Other significant conditions  | art I. 23  | e. Did tobacco  | Did tobacco use contribute to the cause of death?  1  Yes                     |  |                                     |   |  |  |  |
| Records,    | > 0 0  | Completed    |  |  |   |   | 24   | a. Was an                           | 24b. Were auto                                  | opsy findings available                |  |  |
|             | ician: The law<br>certificate has b<br>ector, page 2 sl  | шо           |  |  |   |   | 15   | autopsy<br>performed<br>Yes 2010    | death?  | ompletion of cause of                  |  |  |
| Vital       | ysician: The l<br>is certificate ha<br>director, page  | BeC          | 25. Was case referred to medical   |  |   | 26. F   | Place of Death (Chec.                        |                                     | 10 103  | 20.10                                  |  |  |
| / \         | ys<br>dis  | ToE          | examiner? 1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \)   | Hospital: 1 Inp  | atient 2 ER/Outpatie                                  | nt 3 DOA Other: 4   | Nursing Home                                 | sidence                             | 6 □Other (Speci                                 | fy)                                    |  |  |
| n o         |  |              | 27. Manner of Death  DSNatural 5 ☐ Pending   | 28a. Date of I<br>(Month,  | njury 28b. Time<br>Day Year) Injury                   | Work?   |  | scribe how in                       | jury occurred                                   |  |  |  |
| Division of | or Attending ifter death. Director: After in by the fune   | tificati     | 27. Manner of Death    Statural   2   Accident   3   Suicide   4   Homicide   4   |  |   |   |  |                                     |   |  |  |  |
| ۵           | To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the   |              | 29a. Certifier 1 Sertifying F  | Physician: To the be   | est of my knowledge, dea<br>s of examination and/or i | th occurred at the time, dat  | e and place, and due                         | to the cause                        | (s) and manner as s                             | stated.                                |  |  |
|             | thin 24<br>thin 24<br>the Formplete  | Medical      | one)  29b. Signature and title of certifier  | and manner   |   | 29c. License numl   |  |                                     | Date signed (Month,                             |  |  |  |
|             | will   |              | Hhis   | Ha   | rude  | M DI  | +6473  | 3 3                                 | uly 1   | 0,2006                                 |  |  |
|             |  |              | 30. Name and address of person wh  | lam, M   | D; 1130   | OPAL  | CT.;   | Hag                                 | erstow  | on, MD 21741                           |  |  |
|             | St<br>Regist   | ate          | 31. Date filed (Month, Day, Year)  | 4897   | istrar's Signature                                    | 1 -0  | ,  |                                     | )   |  |  |  |
| DH          | IMH 17 Rev 1/2   | ~ .          | 001, 23  | LUUU A   | Sie B   | ingered   |  |                                     |   |  |  |  |

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar 22536 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2006 **Physician** Month June 29, Leonard Lewis Baker 10:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14378 Bay Water Court Dowell Calvert | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Min. | Mar 21, 1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 □ F 81 579-26-7529 Yrs Director ILUsual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Itams 23a or 28a-f ahow the Medical Examinar must be notified at Washington, DC 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1018 Papermill Court NW 20007 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ₹Yes 2 No Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ Specify: 3 Widowed 4X Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygiei Importent: if Item 27 is marked other it any injury or other treumatic avant, Ita 2002. Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Baker Clarence Thomas Ava Crystal Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard M. Baker (son) 6810 Louise Lane Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 3, 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 2006 Suitland, MD 21. Signatur Juneral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Cary J. Goff 8125 Southern Maryland Blvd. Owings, MD 20736 Ran1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) melanoma metastatic **Physician** 3 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit To the Hospitet or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Records, P.O. Box 68760, by Physician/Medical nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? been signed by the ette should be deteched for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2.200 1 Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year District of Columbia 7600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Cohenno, 3800 Reservoir RONW, Washington DC 20007

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 0 3 2006

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene UU6

For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 29<sup>ay</sup> June 2006 **Physician** 4:35 Рм John Metz Baer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Williamsport Washington Homewood Retirement Center 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 15 M 2□F 215-20-8788 97 MD Director Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylar nant of Health and Mental Hygiene.
and: if item 27 is marked other then "naturel, or iteme 23a or 28a-f show use it item 27 is marked other then "naturel, or other traumatic event, its Medical Examination matter inclined at 1 Yes 2 No Washington Hagerstown Director 10f. Zip Code 21742 10g. Citizen of What Country? 10e. Street and Number 13216 Hillandale Road US Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White If Yes, Give Year or Dates: Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Food Packing President 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leah Bertie Metz Adam Daniel Baer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13216 Hillandale Road, Hagerstown, MD 21742 Joan C. Baer / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 07/06/2006 Hagerstown, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service License 305 N. Potomac Street, Hagerstown, MD 21740 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the attending of the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Yes After this certificete has been si funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe rmed7 2 No BITPL 1 ☐ Yes SIOL To the Hospitel or Attending Physician: Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA W Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: s efter dec. 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) bress of person who completed cause of death (Item 23a) (Type, Paint) 30. Nad MIL 's Signature State JUL 0 6 2006 Registrar

|                            |  |                  | 1 - For<br>State<br>Registrar  | State of N                              | <b>lar</b> ylar |                              | artmen<br><i>rtificat</i> |                    |                   | and M            |                                 | giene<br>Reg. No | ZIIIIh                           | 225                              | 538                |
|----------------------------|--|------------------|--|---|-----------------|------------------------------|---------------------------|--------------------|-------------------|------------------|---------------------------------|------------------|----------------------------------|----------------------------------|--------------------|
|                            | Physici  | an.              | 1. Decedent's Name (First, Middle, Las   | t)                                      |                 | -                            |                           |                    |                   |                  | 2. Date of De<br>Month          | ath<br>Da        | y Year                           | 3. Time of                       | Death              |
|                            | Physici<br>/Medio  |                  | JANE LAIDLAW BRYAN   |   |                 |                              | ,                         |                    |                   |                  | JUNE 2                          | 1, 2             | 006                              | 10:20                            | A M                |
|                            | Examir   | ner              | 4a. Facility Name (If not institution, give  |   | r)              |                              |                           |                    | Location of       | of Death         |                                 |                  | . County of Death                |                                  |                    |
|                            |  |                  | WASHINGTON ADVENTIST   |   |                 |                              | TAKOMA                    |                    | -                 | 0411             |                                 |                  | ONTGOMERY                        |                                  |                    |
|                            | Funeral  |                  | 5. Social Security Number 6. Se  | x<br>□M 2☐XF 7.7                        | Age (In yrs.    | last birthday)               | Months                    | 1 Year<br>Days     | If Under<br>Hours | Min.             | 8. Date of Bird<br>(Month, Da   | y, Year)         | Coui                             |                                  |                    |
|                            | Director   |                  | 578-26-1631 Usual Residence of Decedent  |   |                 | 84 Yrs.                      |                           |                    |                   |                  | JUNE 18,                        | 192              | 2 WASHIN                         | GTON, D                          | <u> </u>           |
|                            | /land  |                  | 10a. State 10b. County   |   | 10c. Cit        | ty, Town or Lo               | ocation                   |                    |                   |                  |                                 |                  | 1                                | 0d. Inside Cit                   | y Limits           |
|                            | Man Han  | ţ                | MARYLAND PRINCE GEO  | RGES                                    | ADEL            | PHI                          |                           |                    |                   |                  |                                 |                  |                                  | 1 🗆 Yes                          | 2 📉 No             |
|                            | 1284 T   | lrec             | 10e. Street and Number   |   |                 |                              | 10f. Zip                  | Code               |                   |                  |                                 | 10g. Cit         | tizen of What Cour               | ntry?                            |                    |
|                            | 7 wit  | Funeral Director | 9280 ADELPHI ROAD, AP  | T. 203                                  |                 |                              | 207                       | 783                |                   |                  |                                 |                  | U.S.A.                           |                                  |                    |
|                            | ee E   | ner              | 11. Marital Status   | 12. Was Deceder<br>Armed Forces         | t Ever in U     | .S. 13.1                     | Was Dece                  | dent of H          | ispanic Orig      | gin? (Spe        | ecify Yes or No<br>Rican, etc.) |                  | 14. Race - Americ                |                                  |                    |
| 9                          | after or its   | E                | 1 X Never Married 2 Married  | 1 ☐ Yes 2 2<br>If Yes, Give             |                 |                              | ii ≀es, spec<br>1 □ Yes   | 37                 | Specify:          | i, rueno         | nican, etc.)                    |                  | Black, White,                    | etc.                             |                    |
| g                          | iral',   | d by             | 3 Widowed 4 Divorced   | Year or Dates                           | :               |                              | 103                       | 263140             | эрвспу.           |                  |                                 |                  | Specify: WHIT                    | Е                                |                    |
| N<br>T                     | within 72 hours after deeth with the Maryland<br>ene.<br>Than "natural", or itama 23e or 28e-f ehow<br>a Madical Examinar must be notified at  | Completed        | 15. Decedent's Ed<br>(Specify only highest grad  |   |                 | 16a. Dece<br>(Give           | kind of wo                | rk done o          | durina mosi       | t of worki       | ng                              | 16b. K           | ind of Business/In               | dustry                           |                    |
| 12                         | then the   | gu               | Elementary/Secondary (0-12)  | College (1-4o                           | r 5+)           |                              | DO NOT U                  |                    |                   |                  |                                 | TO A NII         | ZTNO                             |                                  |                    |
| 22                         | Hygie<br>ther<br>int, II   |                  | 17. Father's Name (First, Middle, Last)  | 4                                       |                 | EXECU.                       | TIVE SE                   | LCKETA             |                   | r's Name         | (First, Middle,                 |                  | KING                             |                                  |                    |
| au                         | d be<br>antal  | Be               | The second secon |   |                 |                              |                           |                    |                   |                  | (First, Middle,                 |                  | ,                                |                                  |                    |
| Maryland 21215-0036        | mark<br>matt   | ၉                | ALBERT HOSEA LAIDLAW  19a. Informant's Name/Relationship (7)   | voe. Print)                             |                 | 19b Mailir                   | na Address                | (Street            | ADELIN            |                  | I Route Numbe                   |                  | OUT<br>or Town, State, Zip       | Codel                            |                    |
| S                          | th ar<br>th ar<br>27 ts  |                  | SUSAN CLARK/NIECE  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                 |                              |                           |                    |                   |                  | RG, PA 19                       |                  | or rown, state, zip              | COOB)                            |                    |
| ē,                         | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. The mortant: If team 27 is marked other than "natural; or itama 23a or 28a-f ahow any njury or other traumatic avant, it a Magical Examinat must be notified at once. |                  | 20a. Method of Disposition   |   | 20b. F          | Place of Dispo               |                           |                    |                   |                  | ate                             |                  | ocation - City or To             | wn, State                        |                    |
| 5                          | ages<br>entol  |                  | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify   |   | •               |                              |                           |                    | 1                 | 7/06/2           | 2006                            |                  |                                  |                                  |                    |
| Baltimore,                 | ortar i  |                  | 21. Signature of Funeral Service Licen   |   | FI.             | LINCOLI                      | 2. Name an                | nd Addres          | s of Facilit      | v                |                                 |                  | TWOOD, MARY                      |                                  |                    |
| ñ                          | Pen<br>Pen<br>Pen<br>Pen<br>Pen<br>Pen<br>Pen<br>Pen<br>Pen<br>Pen   |                  | 1 amanda   | Ludow                                   | ia.             | H:                           | INES-RI                   | INALD:             | I FUNEI           | ÁAL HO<br>E AVEN | OME, INC.                       | ER S             | PRING, MARY                      | TAND 20                          | 904                |
|                            |  |                  | 23a. Part1. Enter the disease, or comp   | lications that caus                     | ed the deat     |                              |                           |                    |                   |                  |                                 |                  | 11110, 11111                     | Approximate                      | )                  |
| Ш                          | Physician  |                  | shock, or heart failure. List only of<br>Immediate Cause (Final  | TRE                                     | . 1             | · . 1                        |                           | -                  | T .               | 60               |                                 |                  |                                  | Onset and D                      |                    |
|                            | /Medical   |                  | disease or condition resulting in death)   | a. Due to (or a                         |                 | / Ya P                       | my_                       |                    | - us              | uth              | GRAR                            | 4                |                                  |                                  |                    |
|                            | Examiner   |                  |  |   | Se              | bsi                          | S                         |                    |                   |                  |                                 | 1                |                                  |                                  |                    |
|                            |  | Jer              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   | b. Due to (or a                         | s a conseq      | u ce of):                    |                           | 6                  | )                 |                  |                                 |                  |                                  |                                  |                    |
|                            | cuted<br>nd<br>ransi   | Examiner         | that initiated events  | · /                                     | 13 E            | irah                         | m                         | I                  | he                | 1 m              | onia                            |                  |                                  |                                  |                    |
| o                          | e exe<br>ien ai<br>urial-t   | E                | resulting in death) Last   | Due to (or a                            | _ `             |                              |                           | - 1                |                   |                  | Pailu                           |                  |                                  |                                  |                    |
| 8760,                      | cate be executed<br>physicien and<br>the burial-transit  | dical            |  | d                                       | mg              | esh'                         | 11                        | he                 | ent               | - 1              | -zila                           | ~ c              |                                  |                                  |                    |
|                            | artific<br>ing p   | Mec              | IF FEMALE:   |   | ,               |                              |                           |                    |                   |                  |                                 |                  |                                  |                                  |                    |
| Вох                        | death certific<br>e attending p<br>id for use as   | by Physician/Med | 23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, outcom<br>1 ☐ Live birth   | 2 Feta          | Ideath 3                     | Ectopic pr                |                    |                   |                  |                                 |                  | 23d. Date of delive<br>Month     | ,                                |                    |
| <u>.</u>                   | the a  | /slc             | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4□Pregnant<br>9□Unknown                 | at time of d    | leath 5                      | Other (sp                 | ecify)             |                   |                  |                                 |                  | MOIIII                           | Day Y                            | ear                |
| P.O.                       | that the de<br>ned by the<br>detached  | F.               | Part II. Other significant conditions co   | ntributing to death                     | but not res     | ulting in the u              | nderhina c                | 21160 000          | on in Part I      |                  | 23e Did to                      | obacco i         | use contribute to th             | a cause of de                    | neth?              |
| Division of Vital Records, | 5 5  |                  |  |   |                 | and an area                  |                           | addo give          | JI 11 7 Q. C 1.   |                  |                                 |                  | □No 3□Prob                       |                                  |                    |
| ဂ္ဂ                        | w requir<br>been s<br>should   | Completed        |  |   |                 |                              |                           |                    |                   |                  |                                 |                  |                                  |                                  |                    |
| ě                          | has<br>ne las  | μĒ               |  |   |                 |                              |                           |                    |                   |                  | 24a. Was<br>autop               |                  | 24b. Were autoprior to cordeath? | osy findings a<br>npletion of ca | vailable<br>use of |
| <u></u>                    |  |                  | 00.11  |   |                 |                              |                           |                    |                   |                  |                                 | 2 <b>⊠</b> No    |                                  | 2□ No                            |                    |
| Ž                          | Physician: The lav<br>this certificete has<br>ral director, page 2   | Be               | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  | Hospital:                               |                 |                              |                           | Othe               |                   |                  | (Check only o                   |                  |                                  |                                  | _                  |
| ō                          | Phy<br>rthis<br>srald  | 2                | 27. Manner of Death  | 28a. Date of In                         |                 | ER/Outpatien<br>28b. Time of |                           | <u></u>            | 4 1 140           |                  | ne 5 ☐ Resid<br>28d. Describe h |                  | 6 Other (Specify                 | ')                               |                    |
| o                          | th:<br>Afte  | ţ                | 1 X Natural 5 ☐ Pending<br>2 ☐ Accident investigation  | (Month, E                               | ay Year)        | Injury                       | м                         | 8c. Injury<br>Work | (?<br>Yes 2 □ N   |                  |                                 | .011 11101       | y 00001160                       |                                  |                    |
| isi                        | Attending<br>ir death.<br>ector: After<br>by the funer   | ‡ Ca             | 3 ☐ Suicide 6 ☐ Could not be   | 286. Place of I                         | njury - At he   | ome, farm, str               | eet, factory              |                    |                   |                  | 28f. Location (S                | Street an        | d Number or Rura                 | Route Numb                       | per                |
| ă                          | afte i Dir   | Certification;   | 4 Homicide   | building,                               | etc. (Specif    | (y)                          |                           |                    |                   |                  | City or Tou                     | vn, State        | )                                |                                  |                    |
|                            | To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral   |                  | 29a. Certifier 1 Certifying Ph   | sician: To the bes                      | at of my kno    | wledge, dualit               | n cenumed                 | at the tive        | ia date and       | d plane, a       | wid due to the o                | causa(s)         | and manner as st                 | ated.                            |                    |
|                            | ha H<br>in 24<br>ha Fi<br>plete  | edical           | (Check only 2 Medical Exam   | and manner                              | of examina      | ition and/or in              | vestigation,              | , in my of         | oinion, deat      | th occurre       | ed at the time, o               | date and         | I place, and due to              | the cause(s)                     |                    |
|                            | To the within 2 To the comple  | Σ                | 29b. Signature and title of certifier  |   | M               | `                            |                           | . License          |                   | ,                |                                 |                  | te signed (Month, I              |                                  |                    |
| ١,                         | 0  |                  |  |   | MI              |                              |                           | 100                | 06                | 010              | 0                               | 0                | 6-22-                            | 06                               |                    |
| 1                          | O  |                  | 30. Name and address of person who o   | completed cause of                      | death (ften     |                              |                           |                    |                   |                  |                                 |                  |                                  |                                  |                    |
|                            |  |                  | TAlfminh 1C  | AHM                                     |                 |                              |                           |                    | d-Eæst            | ; Sil            | verSpring                       | g, MD            | 20903                            |                                  |                    |
|                            | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)  | 2006 32. Regis                          | trar's Signa    | diture                       | arte                      | 7                  |                   |                  |                                 |                  |                                  |                                  |                    |

|            |  | •                 | For<br>State<br>Registrar   | State                                     | of Maryla                            | and / Depa                                  | artmen<br><i>rtificat</i>             |                     |                            | and M           |                                 | jiene (                   | 2006                             | 22539  |
|------------|--|-------------------|---|---|--------------------------------------|---|---------------------------------------|---------------------|----------------------------|-----------------|---------------------------------|---------------------------|----------------------------------|--|
|            |  |                   | 1. Decedent's Name (First, Mid  | dle, Last)                                |                                      |   |                                       |                     |                            | 1               | 2. Date of Dea<br>Month         | th<br>Day                 | Year                             | 3. Time of Death                                 |
|            | Physici<br>/Medio  |                   | WILLIAM   | DUSTIN                                    | ALLE                                 | N BO  | YCE                                   |                     |                            |                 | 6                               | 27                        | 06                               | 1600 M   |
| ,          | Examir   |                   | 4a. Facility Name (If not institut  | on, give street and n                     | umber)                               |   | 4b. City,                             | Town, or            | Location o                 | of Death        |                                 |                           | unty of Death                    |  |
|            |  |                   | YENINSULA REGI  | WHAT ME                                   | NHA C                                | CONTEC                                      |                                       | 54                  | 11584                      | 114             |                                 |                           | Hormic                           | 20   |
|            | Funeral  | · ·               | 5. Social Security Number   | 6. Sex                                    | 7. Age (In yı                        | rs. last birthday)                          | If Under                              | r 1 Year<br>Days    | If Under                   | 24 Hrs.<br>Min. | 8. Date of Birth                | Year)                     | 9. Birthp                        | place (State or Foreign                          |
|            | Director   |                   | 224-51-8707   | 1⊠M 2□F                                   |                                      | 19 Yrs.                                     | MONTHS                                | Days                | 110013                     | D               | (Month, Day<br>ecember 2        | 8, 198                    | 6 Virgi                          | mía  |
|            | <b>p</b> _   |                   | Usual Residence of Decedent   |   | 140                                  |   |                                       |                     |                            |                 |                                 |                           |                                  |  |
|            | how  |                   | 10a. State 10b. Coun  | ty  | 10c.                                 | City, Town or Lo                            |                                       |                     |                            |                 |                                 |                           | 1                                | 10d. Inside City Limits                          |
|            | W W  | 5                 | Maryland Wo   | rcester                                   |                                      |   | Poo                                   | comok               | te Cit                     | ty              |                                 |                           |                                  | 1 ☐ Yes 2 ☒ No                                   |
|            | # P  | Director          | 10e. Street and Number  |   |                                      |   | 10f. Zip                              | Code                |                            |                 | 1                               | 10g. Citizer              | of What Cour                     | ntry?  |
|            | 72 hours after deeth with the Maryland<br>"neturel", or Iteme 23a or 28a-f ehow<br>idical Examiner must be multiled at   |                   | 4341 Jones Roa  | ad  |                                      |   |                                       |                     | 218                        | 51              |                                 |                           | USA                              |  |
|            | ep e   | Funeral           | 11. Marital Status  | 12. Was De<br>Armed                       | cedent Ever in<br>Forces?            | i U.S. 13.                                  | Was Dece                              | dent of Hi          | spanic Ori                 | gin? (Spe       | city Yes or No-<br>Rican, etc.) | 14.                       | Race - Americ<br>Black, White,   |  |
| 9          | or it  |                   | 1 Never Married 2 ☐ M   | If Yes. 0                                 | 2⊠No<br>Sive                         | i   | 1 🗆 Yes                               |                     | Specify:                   |                 |                                 |                           |                                  |  |
| 8          | ref.   | d by              | 3 Widowed 4 Divorc  | ed Year or                                | Dates:                               |   |                                       |                     |                            |                 |                                 |                           |                                  | ite  |
| 21215-0036 | 72 F   | Completed         | 15. Deced<br>(Specify only high   | ent's Education<br>nest grade completed   | 1)                                   | (Give                                       | dent's Usu<br>kind of wo              | rk done a           | turina mosi                | t of workii     | ng                              | 16b. Kind                 | of Business/In                   | dustry   |
| 2          | within<br>iene.<br>then  | ם                 | Elementary/Secondary (0·12  | ) College                                 | (1-4or 5+)                           | IIIO.                                       | DO NOT u                              |                     | ,                          |                 |                                 |                           |                                  |  |
| 2          |  |                   | 12  | 1   |                                      |   | Stude                                 | ent                 | 10 Matha                   | ada Nama        | (First Adidate                  |                           | llege                            |  |
| ī          | be filed<br>ital Hyg<br>od othe<br>event,  | Be                | 17. Father's Name (First, Middle  |   |                                      |   |                                       |                     |                            |                 | (First, Middle,                 |                           | mame)                            |  |
| <u></u> ₹  | 2 should be and Mental is marked or reumatic ever  | ဥ                 | Robert Stuart   | 2   |                                      |   |                                       |                     |                            |                 | mn Prui                         |                           |                                  |  |
| Maryland   | s 1 and 2 should<br>f Health and Mer<br>item 27 is marke<br>other traumatic  | e 8               | 19a. Informant's Name/Relatio   |   |                                      |   | -                                     |                     |                            |                 | Route Numbe                     | 10000                     |                                  |  |
|            | 1 and 2<br>Health  |                   | Tammy Pruitt I  | <u> Boyce (Mot</u>                        |                                      |   |                                       |                     | pad -                      |                 |                                 | _                         |                                  | d 21851  |
| or o       | m O  |                   | 20a. Method of Disposition  1   | n 3 🗀 Removal fro                         |                                      | <ol> <li>Place of Disposers, cre</li> </ol> | matory or                             | me or<br>other plac | e)                         |                 | ate                             | 20c. Locat                | tion - City or To                | own, State                                       |
| Baltimore, | permit. Pages Depertment of I Important: If its eny injury or o  |                   | 4 ☐ Donation 5 ☐ Other  |   |                                      | irst Bap                                    | otist                                 | Ceme                | etery                      | 7/2/            | /2006 I                         | ocomo                     | oke Cit                          | y, Maryland                                      |
| a          | permit. Pag<br>Depertment<br>Important:<br>eny Injury once.  |                   | 21. Signature of Funeral Servi  |   | 1. Coloni                            | H 3   | 2. Name a                             | nd Addres           | s of Facility              | s Fur           | neral Ho                        | ome                       |                                  |  |
| <b>m</b>   | 897 29   |                   | Mary Beth   | Bradshaw-                                 | Pruitt                               |   |                                       |                     |                            |                 |                                 |                           | _Maryl                           | and 21817  |
|            |  |                   | 23a. Part1. Enter the disease, shock, or heart failure. L   | or complications tha                      | t caused the de                      |   |                                       |                     |                            |                 |                                 |                           |                                  | Approximate<br>Interval Between                  |
|            | Physician  |                   | Immediate Cause (Final disease or condition   |   |                                      | 14010                                       | 14. ((1)                              | 00                  |                            |                 |                                 |                           |                                  | Onset and Death                                  |
| 7          | /Medical   |                   | resulting in death)   | aDue t                                    | o (or as a cons                      | sequence of):                               | 141)                                  | 10-5                |                            |                 |                                 | -                         |                                  | JG VIII J  |
|            | Examiner   |                   |   |   | Mo                                   | to vehi                                     | de a                                  | ucide               | nt                         |                 |                                 |                           |                                  | 1  |
|            |  | ē                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. — Due t                                | o (or as a cons                      | sequence of):                               |                                       |                     |                            |                 |                                 | -                         |                                  |  |
|            | uted<br>d<br>ansit   | Ē                 | Cause (Disease or injury that initiated events  | 1   |                                      |   |                                       |                     |                            |                 |                                 |                           |                                  |  |
| Ć,         | exec<br>n an<br>ial-tr   | Examiner          | resulting in death) Last  |   | o (or as a cons                      | sequence of):                               |                                       |                     |                            |                 |                                 |                           |                                  |  |
| 8760,      | cate be executed oblysicien and the burial-transit   | cai               |   | d.  |                                      |   |                                       |                     |                            |                 |                                 |                           |                                  |  |
| 89         | ficate<br>phys   | g                 |   |   |                                      |   |                                       |                     |                            |                 |                                 |                           |                                  |  |
| ŏ          | death certifica<br>ettending ph<br>d for use es t  | Physician/Medical | IF FEMALE:<br>23b, Was decedent pregnant  |   | outcome of pre-                      |   |                                       |                     |                            |                 |                                 | 230                       | I. Date of deliv                 | ery  |
| ă          | ette<br>d for  | clai              | in the past 12 months?  |   | ebirth 2 □ F<br>gnant at time o      |   | ∐Ectopic p<br>☐ Other (s <sub>i</sub> |                     |                            |                 |                                 |                           | Month                            | Day Year   |
| O.         | y the  | iysi              | 9 Unknown   | 9□ Un                                     | known                                |   |                                       |                     |                            |                 |                                 |                           |                                  |  |
| <u>α</u>   | The law requires thet the death certificate be executed the has been signed by the ettending physicien and page 2 should be detached for use es the burial-transit |                   | Part II. Other significant cond   | itions contributing to                    | death but not                        | resulting in the                            | underlying                            | cause give          | en in Part I               | l.              | 23e. Did to                     | bacco use                 | contribute to t                  | he cause of death?                               |
| Records,   | uires<br>sign<br>d be  | d by              |   |   |                                      |   |                                       |                     |                            |                 | 1 🗆 Y                           | es 2 🖭                    | o 3 □ Prol                       | bably 4 Unknown                                  |
| Ö          | w requir<br>been si<br>should I  | Completed         |   |   |                                      |   |                                       |                     |                            |                 | 240 1460                        | 1                         | 14b 18/222 2 4                   | C-do labla                                       |
| že         | The law<br>ste has l   | μ                 |   |   |                                      |   |                                       |                     |                            |                 | 24a. Was autop                  | sv                        | prior to co<br>death?            | opsy findings available<br>empletion of cause of |
| <u> </u>   |  | S                 |   |   |                                      |   |                                       |                     |                            |                 |                                 | 2 No                      |                                  | 2 □ No   |
| of Vital   | Physicien: This certificeral director, p   | Be                | 25. Was case referred to med examiner?  | Hospital:                                 |                                      |   |                                       | Oth                 |                            | e of Death      | (Check only or                  | ne)                       |                                  |  |
| £          | Phys<br>this<br>aldir  | 은                 | 1 ☐ Yes 2 ☐ No  | 11  |                                      | 2 ☐ ER/Outpatie                             |                                       |                     | 4 🔲 NU                     |                 | ne 5 Resid                      |                           |                                  | (y)  |
| Ē          | Ing F  | Certification:    | 27. Manner of Death 1 □Natural 5 □ Pen  | ding (M                                   | te of Injury<br>onth, Day Year       |   |                                       | 28c. Injun<br>Work  |                            | _               | 28d. Describe h                 |                           | ccurred                          |  |
| Division   | Attending in death.  | cat               | Z G / NOCIGORIL   | ld not be                                 | 72/06                                | 11 28                                       |                                       |                     | Yes 2 🔃                    |                 | MUC                             |                           |                                  |  |
| $\leq$     | or At  | E                 |   | minor 200. Pla                            | ce of Injury - A<br>ilding, etc. (Sp | At home, farm, si<br><i>ecity)</i>          | treet, factor                         | y, office           |                            |                 | 28f. Location (S<br>City or Tow | Street and N<br>m, State) | Number or Run                    | al Route Number,                                 |
|            |  |                   |   | 1   |                                      | actury                                      |                                       |                     |                            |                 | R+ 13 Sout                      |                           |                                  | Line   |
|            | To the Hospital within 24 hours of To the Funeral completely filled  | edicai            | (Check only 2 (Check only   | ying Physician: To<br>al Examinar: On the | basis of exam                        | knowledge, dea<br>nnation and/or i          | th occurred                           | at the tim          | ne, date ar<br>pinion, dea | nd place, a     | and due to the ded at the time. | cause(s) an               | nd manner as s<br>ace, and due t | stated.<br>o the cause(s)                        |
|            | the the population   | led               | one)  | and m                                     | anner stated.                        |   |                                       |                     |                            |                 |                                 |                           |                                  |  |
|            | Viit<br>To   | Σ                 | 29b. Signature and the of cen   | Пент                                      |                                      |   | 29                                    | ic. Licens          | e number                   | 97              |                                 | 290. Date s               | signed (Month,                   | Day, Year)                                       |
|            |  |                   | ) W   |   |                                      |   |                                       | 1).                 | 7                          | ( )             |                                 | 60                        | 1106.                            |  |
|            |  |                   | 30. Name and address of pers  | on who completed ca                       | use of death (                       | Item 23a) (Type                             | , Print)                              |                     |                            |                 | 1                               | 1                         |                                  |  |
| _          |  |                   | Chris Snyder  | - 100E                                    | Carrol                               | 54, 54                                      | Hisbu                                 | ryi                 | nd. ¿                      | 2180            | 1                               |                           |                                  |  |
|            |  | ate               | 31. Date filed (Month) Day, Ye  |   | . Registrar's Si                     | ignature                                    |                                       | ) '                 |                            |                 |                                 |                           |                                  |  |
|            | Regist   | rar               | JU!   | 0.3 2006                                  | Flore                                | . 4   |                                       | - 24                |                            |                 |                                 |                           |                                  |  |

# Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. O. O.

|                     |   |                     |   |                                    | State of N  | viaryiano / i                                      |                             | ficate of                                |  |   | giene 2 (<br>Reg. No.              | )06                         | 22540  |
|---------------------|---|---------------------|---|------------------------------------|---|--|-----------------------------|--|--|---|------------------------------------|-----------------------------|--|
|                     | Physici   | an                  | 1. Decedent's Name (Fire  | st, Middle, Last                   |   | \  | 101                         |  | 300000000000000000000000000000000000000              | 2. Dete of De                           |                                    | Year                        | 3. Time of Death                                   |
|                     | /Media  | cal                 | 4a Fecility Neme (If not  | institution aire                   |   | AMC  | 010                         |  | 4b. City, Town, or                                   | Location of Beatl                       |                                    | OO6                         | 2.00   |
|                     | Examir  | ner                 | Vantage Hou   |                                    | Street end numbe  | 11 )   |                             | '  | Columbi  |   |                                    | ard                         |  |
|                     | Funeral   |                     | 5. Social Security Number   | er 6. Se                           |   | Age (In yrs. last bi                               |                             | If Under 1 Year<br>Months Days           | If Under 24 Hrs<br>Hours Min.                        |   |                                    |                             | ace (State or Foreign                              |
| Sa.                 | Director  |                     | 215 07 581  | 4                                  | □M 24K0F  | 87   | Yrs.                        | Joint Days                               | Hours Min.   | Apr 1                                   | 8, 1919                            | Mary                        | Zand   |
|                     | end<br>#  |                     | Usual Residence of Dece<br>10a. State 10b   | . County                           |   | 10c. City, Tow                                     | vn or Local                 | tion                                     |  |   |                                    | 10                          | Od. Inside City Limits                             |
|                     | Many<br>Fred  | to                  | MD F  | loward                             |   | Colu   | mbia                        |  |  |   |                                    |                             | 1 ☐ Yes 21 No                                      |
|                     | r 28a   | 2                   | 10e. Street end Number  | lowara                             |   | COIU   |                             | 10f. Zip Code                            |  |   | 10g. Citizen of V                  | What Count                  | ry?  |
|                     | th wit  | alD                 | 5400 Vantag   | ge Poin                            | t Rđ Apt  | 1111   |                             | 21044                                    | ļ  |   | United                             | State                       | es.  |
| 020                 | be filed within 72 hours after deeth with the Marylend ttal Hygiene. ad other than "naturel", or Hems 23e or 28a-f show event, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status  1 Never Married  3 Widowed 4 1  | 2 Married                          | 12. Was Deceder<br>Armed Forces<br>1 ☐ Yes 2 ☐<br>If Yes, Give<br>Year or Dates | s?<br>XNo  |                             | s Decedent of Hes, specify Cube          | lispanic Origin? (S<br>en, Mexicen, Puer<br>Specify: | Specify Yes or No<br>to Rican, etc.)    | 14. Rac<br>Blac<br>Specify         | e - America<br>ck, White, e |  |
| 2-0                 | 72 ho   | ted                 | 15. I   | Decedent's Edu<br>nly highest gred | ication   | 16a  | . Deceden                   | it's Usual Occup                         | ation<br>during most of wo                           | rkino                                   | 16b. Kind of Bu                    |                             |  |
| Maryland 21215-0020 | ne.   | Completed by        | Elementary/Secondary  |                                    | College (1-4o   | or 5+)   | Tife. DO                    | NOT use retired                          | d)   | iking                                   |                                    |                             |  |
| d 2                 | filed with<br>Hygiene.<br>Ither than  | ပ္ပ                 | 12<br>17. Father's Name (First,   | Middle Lest)                       |   |  | Hon                         | nemaker                                  | 18 Mother's Na                                       | me (First, Middle,                      | Own H                              |                             |  |
| lan                 | a la b  | To Be               | Herbert C.  |                                    |   |  |                             |  |  | E. Chile                                |                                    | ,,,                         |  |
| ary                 | 2 should be<br>and Mantal<br>is merked o  | F                   | 19a. Informant's Name/F   |                                    | /pe, Print)   | 198  | o. Mailing                  | Address (Street                          | and Number or Ri                                     |   |                                    | State, Zip (                | Code)  |
|                     | B 章 2 m   |                     | Kenneth J.  | Baumanı                            | n/Husban  |  |                             |  |  | Apt 11:                                 | ll Colum                           | bia,                        | MD 21044   |
| Baltimore,          | 6 O   |                     | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cre   |                                    | Removal from Stat   | 20b. Place of cemete                               | of Dispositi<br>ory, cremat | on (Name of<br>tory or other place       |  | Date                                    | 20c. Location -                    | City or Tow                 | vn, State  |
| ţ                   | parmit. Peg<br>Depertmant<br>Important: If<br>any injury o  |                     | 4 Donation 5 □  | Other (Specify)                    |   |  |                             | je Cemet                                 |  | 6-2006                                  | Baltimo                            | re, M                       | ID   |
| Bal                 | parmit. Pe<br>Depertmar<br>important:<br>any injury<br>pnce.  |                     | 21. Signature of Funeral  | Service Licens                     | - with  | M01044   |                             | iame and Addre                           | На   | ***                                     |                                    |                             | ly FH Inc.<br>MD 21043                             |
| -                   |   |                     | 23a. Part1. Enter the dis<br>shock, or heart faile  | ease, or complure. List only o     | ications that cays<br>ne cause on eech  | ed the death. Do<br>line.                          | not enter t                 | the mode of dyin                         | ng, such as cardia                                   | c or respiratory a                      | rrest,                             | ; 1                         | Approximate<br>Interval Between<br>Onset and Death |
| ×                   | Physician /Medical  |                     | Immediate Cause (Final  |                                    | VALE  | umo  | AL HO                       | -  |  |   |                                    |                             |  |
| Æ,                  | Examiner  |                     | disease or condition<br>resulting in death)   |                                    | a. 110 C  | Due to (or as a                                    |                             |  |  |   |                                    | 1                           |  |
|                     | ס א   | ne                  |   | -                                  | ST  | ROKE   | =                           |  |  |   |                                    |                             |  |
|                     | tificate be axecuted<br>ig physician and<br>as the bunal-transit  | Examiner            | Sequentially list conditio  | ns,                                | )   | Due to (or as a                                    | conseque                    | nce of):                                 |  |   |                                    |                             |  |
| 68760,              | be a)<br>sician<br>buria  | iei<br>E            | Sequentially list condition if eny, leading to immedicause. Enter Underlying Ceuse (Disease or injury that initiated events | 7                                  | c   |  |                             |  |  |   |                                    |                             |  |
| 687                 | ficate<br>p phys<br>as the  | edicai              | resulting in death) Last  |                                    |   | Due to (or as e                                    | conseque                    | nce of):                                 |  |   |                                    | -                           |  |
| Box                 | aath cert<br>attanding<br>I for usa   | Z.                  |   |                                    | d   |  |                             |  |  |   |                                    |                             |  |
|                     | daat<br>he att  | Physician/N         | Part II. Other significent  | conditions cor                     | ntributing to death   | but not resulting i                                | in the unde                 | orlying cause giv                        | en in Part I.  | 23b. Did                                | tobacco use co                     | ntribute to                 | the cause of death?                                |
| P.0                 | The law requires that the death cer<br>ate has been signed by the attandin<br>page 2 should be datached for usa   |                     | RHEUN   | ATO                                | 10 Ar   | 2746   | 217                         | 21.                                      |  | 10                                      | Yes 2□ No                          | 3 Prob                      | ably 4 Unknown                                     |
| ds,                 | ires that<br>signed I<br>d be dat   | Completed by        |   |                                    |   |  |                             |  |  | 24a Was                                 | an autopsy                         | 24h Wei                     | re autopsy findings                                |
| S                   | v require<br>been sig<br>should t   | ete                 |   |                                    |   |  |                             |  |  |   | ermed?                             | avai                        | ilable prior to                                    |
| Re                  | The law<br>ate has<br>page 2  | E C                 |   |                                    |   |  |                             |  |  | 10                                      | Yes 2 No                           | 1 _                         | leath?   |
| Vital Records,      |   | Be C                | 25. Was case referred to  | medical                            |   |  |                             |  | 26. Place of De                                      | ath (Check only o                       |                                    |                             | 100 2010   |
| of V                | G io  | To B                | examiner?<br>1 ☐ Yes 2 ☑ No   | ŀ                                  | Hospital:<br>1 ☐ Inpa   | ıtient 2 ☐ ER/O                                    | utpatient                   | 3□ DOA Oth                               | er.  | lome 5□ Resi                            |                                    | er (Specify)                | HUXX   |
| 0 0                 | The The   |                     | 27. Manner of Death 1 ☑Natural 5 [  | Pending                            | 28e. Date of In<br>(Month, D  |  | Time of<br>Injury           | 28c. Injur<br>Wor                        |  | 28d. Describe                           | how injury occur                   | red                         |  |
| Sio                 | Attanding or death.   | cati                | 2 Accident  | investigation  Could not be        | One Pleas of I  | Inium. At home 6                                   |                             |  | Yes 2 □ No   | 20f Leasting /                          | Street and Numb                    | nor or Bural                | Pouto Alumbo                                       |
| Division            | after d   | Certification:      | 4  Homicide   | determined                         |   | Injury - At home, fa<br>etc. <i>(Specify)</i>      | arm, street                 | i, factory, office                       |  | City or To                              | Street and Numb<br>vn, State)      | er or nurar                 | Noble Number,                                      |
|                     | To the Hospital or Attandi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely fillad in by tha fi  | edicai C            | 29a. Certifier 1 (Check only one)   | Certifying Phys<br>Medical Exami   | sicien: To the bes  | st of my knowledge<br>of examination en<br>stated. | e, death or<br>nd/or inves  | ccurred at the tir<br>stigation, in my o | ne, date and place<br>pinion, death occu             | e, and due to the<br>arred at the time, | cause(s) and ma<br>date and place, | inner as sta<br>and due to  | ated.<br>the cause(s)                              |
|                     | To the within 3   | Me                  | 29b. Signature and title of   | of certifier                       | AAAA  |  |                             | 29c. Licens                              | e number   | _                                       | 29d. Date signe                    |                             | Jay, Year)   |
|                     |   |                     | > Ka  | pkell                              | YW.   |  |                             | DS                                       | 248  |   | July                               | 300                         | ,2006  |
| $\sim$              | ) Ton   |                     | 30. Neme and address of   | f person who co                    | ompleted cause of   | death (Item 23a)                                   | (Type, Pri                  | nt) KE                                   | NNET   | H ST                                    | = H, M                             | D                           | >- '   |
| 7                   |   |                     | 31. Date filed (Month, Da   | N Year)                            | 30 PMin   | strar's Signature                                  | IE -                        | 34 T                                     | BALTU  | noisa                                   | MI                                 | 121                         | 201.   |
| 6.                  | Sta<br>Registr  |                     | III   | - ~                                | 9/4   | en &   | Son                         | with                                     |  |   |                                    |                             |  |

State of Maryland / Department of Health and Mental Hygiene [ ] [ ] Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 9, 4.07 pm M **Physician** 2006 Lawrence Willis Burdick, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street and number) Examiner Garrett Friendsville 1421 Friendsville-Addison Rd. 8. Date of Birth (Month, Day, Year) Sept. 23, 1927 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number New York **Funeral** Days Hours Min 1 **X** M 2 □ F 78 Director 067-22-3583 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or Itams 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 No Director Friendsville Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21531 1421 Friendsville-Addison Rd. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Ita ury or other traumatic event, the Madical Examina XYes 2 □ No 1 ☐ Never Married 2 ☐ Marned 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: White ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Trucking Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Creighton Robert Burdick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lawrence W. Burdick, Jr./Son 866 Terra Alta Lake Rd., Terra Alta,WV 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury of ange: Country Side Crematory July 10,2006 Davidsville, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD Approximate Interval Between Onset and Death 23a. Part1. Effect e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heal failure. List only one cause on each line. Immediate C use ( inal disease or con n resulting in death) **Physician** a STACK IV NONSMALL CELL CO LUNG /Medical Due to (or as a consequence of) Examiner METS - LIVER, SPINE MEDIASTINAM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate Division of Vital or Attending Physician: 26. Place of Death Check only one 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 2 this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospitel or Atterwithin 24 hours after design to the Funeral Director completely filled in by the 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7-10-06 M who completed cause of death (Item 23a) (Type, Print) 30. Name and address of A. Walch OalCland, 311 North 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 2006 Registrar

|                |   |                | Please   | State of M   |                 |                         | <b>delible ink</b><br>artment of l                           |   | -   |                            | egible.                                      | 2251.2                              |
|----------------|---|----------------|--|--|-----------------|-------------------------|--|---|---|----------------------------|--|-------------------------------------|
|                |   |                | 1 - State<br>Registrar   |  |                 | Ce                      | rtificate of   | Death                                     |   | Reg. No.                   | .000   | 22092                               |
| * .            | Physici   |                | Decedent's Name (First, Middle, La     Eleanor Flor  |  | 3eckmaı         | n                       |  |   | 2. Date of De Month July                  | eath<br>Day<br><b>9</b>    | Year 2006                                    | 3. Time of Death $10 : 00 \ P^{M}$  |
|                | /Medic<br>Examir  |                | 4a. Facility Name (If not institution, given   |  |                 |                         | 4b. City, Town, o  | or Location of Dea                        | -   |                            | ounty of Death                               | 10.00 1                             |
|                | E Admin   | 1808           | Oakland Nursing  | & Rehabili   | itation         | 1                       | 0aklan   | d   |   | Ga                         | rrett  |                                     |
| 0              | Funeral   |                | 5. Social Security Number 6. 5   | Sex 7. Ag  | e (In yrs. las  |                         |  | If Under 24 Hrs                           |   | rth                        | 9. Birth                                     | place (State or Foreign             |
|                | Director  |                | 5//-40-900/  | 1□M 2\XF   | 77              | Yrs.                    | Worths Days  | Hours Min                                 | April                                     |                            | 29 Mar                                       | yland                               |
|                | pur *   |                | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, T    | Town or Lo              | ocation  |   |   |                            |  | 10d. Inside City Limits             |
|                | atho and  | ō              | ,  |  |                 |                         | oution   |   |   |                            |  | 1 ☐ Yes 2∜☐ No                      |
|                | 28a-1   | Director       | MD Garrett  10e. Street and Number   |  | 0ak             | Land                    | 10f. Zip Code  |   |   | 10g Citize                 | n of What Cou                                |                                     |
|                | with Mary   | ۵              | 527 Lynndale Ro  | vad.   |                 |                         | 21550  |   |   |                            | ed Stat                                      | •                                   |
|                | death<br>The 2%   | Funeral        | 11. Marital Status   | 12. Was Decedent   | Ever in U.S.    | 13.                     | Was Decedent of I  |   | Specify Yes or No                         |                            | . Race - Ameri                               |                                     |
| 0              | r lear  | F              | 1 Never Married 2 Married  | Armed Forces?<br>1 ☐ Yes 2 ☑ If Yes, Give                            | No              |                         |  |   | to Rican, etc.)                           |                            | Black, White,                                |                                     |
| 2-003b         | be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or llema 23a or 28a-f ahow event, the Medical Exertifiar must be notified at | by             | 3 N Widowed 4 Divorced   | Year or Dates:   |                 |                         | 1□Yes 2XINo  | Specify:                                  |   | S                          | pecify: Whi                                  | .te                                 |
| ်<br>သ         | 72 ho<br>natu   | Completed      | 15. Decedent's E<br>(Specify only highest gra  | ducation<br>a de completed)  | 1               | 6a. Dece                | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | pation                                    | ndkina                                    | 16b. Kind                  | of Business/In                               | dustry                              |
| 7              | within iene.  | Jqu            | Elementary/Secondary (0-12)  | College (1-4or   | 5+)             |                         |  |   | 9   | _                          | _  |                                     |
| 7              | filed w<br>Hygier<br>Sther tl   | S              | 12   |  |                 | Sal                     | es Clerl   | T   |   | <u> </u>                   | . Stor                                       | e                                   |
| בב             | tal H   | Be             | 17. Father's Name (First, Middle, Last   |  |                 |                         |  |   | me (First, Middle                         | , Maiden Si                | umame)                                       |                                     |
| Maryland       | should by   | 70             | Daniel M. Lipso<br>19a. Informant's Name/Relationship  |  |                 | 10h Maili               | - Add /Ct  | Maude                                     | 1140 1                                    | Moats                      |  |                                     |
| <u> </u>       | d 2 sho<br>th and<br>7 Ism<br>traum   |                | Mr. Gary Beckman   |  |                 |                         | ng Address <i>(Str</i> eet<br>Lynndale                       |   |   |                            | 550  | Code)                               |
|                | is 1 and 2 should<br>if Health and Men<br>Item 27 is marke<br>other traumatic   |                | 20a. Method of Disposition   | 1, 3011  | 20b. Plac       |                         | esition (Name of matory or other pla                         |   | Date Date                                 |                            | ition - City or To                           | own State                           |
| <u>ē</u>       | Pages<br>nent of<br>int: If It<br>iry or o  |                | 1X Burial 2 ☐ Cremation 3 ☐  |  |                 |                         |  |   | 12/06                                     |                            |  |                                     |
| altimore,      | artme   |                | 4 □Donation 5 □ Other (Special Signature of Funeral Service Lice   |  | Pie             |                         | Valley  Name and Addre                                       |   | 12/06<br>urdock-D                         |                            | and, MD                                      |                                     |
| n<br>n         | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.  |                | Hore .   | Aurit.   |                 |                         |  |   |   |                            |  | . ноше<br>I, MD 21550               |
| 30             | ğ (   |                | 23a. Part1. Enter the disease, or com  | plications that caused   | the death.      | Do not ent              | er the mode of dyii  |   |   |                            | Oakrand                                      | Approximate                         |
|                | %<br>Dhyaisian  |                | shock, or heart failure. List only<br>Immediate Cause (Final   | one caust on each li   | ne.             |                         |  | 0   |   |                            |  | Interval Between<br>Onset and Death |
|                | Physician<br>/Medical   |                | disease or condition resulting in death)   | Due to for as  | emyo            |                         | liol in  | outish                                    |   |                            | 1  | sminutes                            |
|                | Examiner  |                | 1  | ather  | occ le          | while                   | - cordin   | vescular                                  | - dico                                    | 150                        |  | 5 300000                            |
|                |   | Jer            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Due to (or as  | a consequen     | ce of):                 | MIO  | 14 300/(01                                |   | CJE                        |  | YUR                                 |
|                | cutec<br>nd<br>ransi  | Examiner       | that initiated events  | c  |                 |                         |  |   |   |                            |  |                                     |
| Ω<br>Q         | e be executed<br>rsicien and<br>e burial-transit  |                | resulting in death) Last   | Due to (or as  | a consequen     | ice of):                |  |   |   |                            |  |                                     |
| -              | icate b<br>physic<br>s the b  | lical          | •  | d  |                 |                         |  |   |   |                            |  |                                     |
| ρ<br>Ω<br>X    | The law requires that the death certificate tie has been signed by the attending phys age 2 should be detached for use as the   | Physician/Medi | IF FEMALE:   | 00-11  |                 |                         |  |   |   |                            |  |                                     |
| X<br>D         | attend<br>attend<br>for us  | lan            | 23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, outcome   | 2 Fetal de      | ath 3[                  | Ectopic pregnancy  | у   |   | 230                        | <ul> <li>Date of delive<br/>Month</li> </ul> | ery<br>Day Year                     |
| j.             | he de   | yslo           | 1 □ Yes 2 ☑ No<br>9 □ Unknown  | 4□Pregnant at<br>9□Unknown   | time of deatr   | 1 5                     | Other (specify) _  |   |   |                            |  |                                     |
| 7              | w requires that the de<br>been signed by the<br>should be detached  | , Ph           | Part II. Other significant conditions  | contributing to death b  | ut not resultin | g in the u              | nderlying cause giv  | en in Part I.                             | 23e. Did t                                | obacco use                 | contribute to the                            | ne cause of death?                  |
| VItal Records, | uires<br>n sign<br>lid be   | d by           | Christ obert   | runtire  | Pyl             | mes                     | 9 4 4 0  | lisease                                   | 1 1                                       | Yes 2□1                    | No 3□Prot                                    | pably 4 Unknown                     |
| S              | w req   | Completed      | La I Fla   | rillation  | F .             | 0100                    | brorusu  | 1.  | 24a. Was                                  | an s                       | 24h Were auto                                | psy findings available              |
| T<br>T         | sician: The law<br>certificete has b<br>irector, page 2 s   | E              | 1 31 31  | rinticox   |                 |                         | و د ۱۷۵۶۹  | -4/62                                     | auto                                      | psy<br>ormed?              | prior to coi<br>death?                       | mpletion of cause of                |
| <u>ra</u>      |   | e C            | 25. Was case referred to medical   |  |                 |                         |  | 26 Place of Do                            | 1 Yes                                     | 2/No                       | 1 🗆 Yes                                      | 2□ No                               |
| >              | ysici<br>s cer<br>direct  | 0 13           | examiner?<br>1 ☐ Yes 2 No  | Hospital:<br>1 ☐ Inpatie   | nt 2□ER         | /Outnatier              | t 3 DOA Oth  | 000                                       | ath <i>(Check only o</i><br>Home 5 ☐ Resi |                            | Other (Security                              |                                     |
| 0              | g Ph<br>Berthi<br>Beral   | lon; T         | 27. Manner of Death  | 28a. Date of Inju<br>(Month, Da)                                     | ry 28           | b. Time of              |  |   | 28d. Describe                             |                            |  | 77                                  |
| <u>ö</u>       | ath.<br>r: Afr  | atlo           | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation   |  | , rear)         | Injury                  |  | Yes 2 □ No                                |   |                            |  |                                     |
| UIVISION       | r Atte  | ertificat      | 3 Suicide 6 Could not b  |  | ury - At home   | , farm, str             | eet, factory, office   |   | 28f. Location (                           |                            | Vumber or Rura                               | I Route Number,                     |
| ב              | Italo<br>rs aft<br>ral Di<br>led in   | O              |  |  |                 |                         |  |   |   |                            |  |                                     |
|                | To the Hospital or Attending Physician: white 24 hours after death or 25 the Funeral Director: After this certifice completely filled in by the funeral director, to      | edical         | 29a. Certifier (Check only one)  1. Certifying Phase Cert | nysician: To the best of<br>miner: On the basis of<br>and manner sta | examination     | dge, death<br>and/or in | n occurred at the tir<br>restigation, in my o                | me, date and place<br>ppinion, death occu | e, and due to the<br>urred at the time,   | cause(s) an<br>date and pl | id manner as si<br>ace, and due to           | tated.<br>the cause(s)              |
|                | omple   | Me             | 29b. Signature and title of certifier  |  |                 |                         | 29c. Licens  | e number                                  |   | 29d. Date s                | signed (Month,                               | Day, Year)                          |
|                | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,   |                | > Truli  | Tan.   | M               | D.                      | Dou  | 25750                                     | 1   | Jul                        | 10. 2  | _00/                                |
|                | 0   |                | 30. Name and address of person who   | completed cause of d   |                 |                         | Print)   |   |   |                            | 7  |                                     |
|                | ゴ   |                | Walter K. No   | umann  | MI              | P                       | O Bux  | 25759<br>247 A                            | teciden                                   | +MI                        | 0 215  | 20                                  |
| 746            | Sta   |                | 31. Date filed (Month, Day, Year)  |  | ar's Signature  |                         | 6  |   |   |                            |  |                                     |
| 100            | Registr   | ar             | JUL I U  | 2006   | 200             | × 1                     | manuff o   |   |   |                            |  |                                     |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Month Physician** Edress Elizabeth Bosley /Medical 4a. Facility Name (If not institution, give street and number, Examiner Jemoria 8. Date of Birth (Month, Day, 9 (Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 24 H **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 91 220-10-0351 Maryland Director 1915 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD. Garrett Yes 2□No Director Bloomington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 16 Virginia Ave. 21523 United States Itama 23a Funerai death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. filed within 72 hours after 1 ☐ Yes 21/21√40 If Yes, Give Year or Dates: .0 1 Never Married 2 Married white 1 ☐ Yes 2/2√No Specify: þ 3 √Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than Housework Homemaker unknown of Health and Mental Hygis filtem 27 is marked other ir other traumatic avant, permit. Pages 1 and 2 should be filed.
Department of Health and Mental important: If Item 27 is many injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Scott Elliott Eugenia Kennell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17839 Maryland Highway, Swanton, Maryland 21561 Margaret Paugh/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 07/08/ Burial 2 Cremation 3 Removal from State Bloomington, Maryland Bloomington Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home ac 111 Church St., Westernport, Maryland 21562 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intracted executed) Due to (or as a consequence of) Examine or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physicien a s the burial-( Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icete hes been sig. , page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2 No 1 Yes 2 No ector, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 Alpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2X No 2 ER/Outpatient 3 DOA funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturat 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the test of my knowledge death occurred at the time, date and place, and the to the date and place, and making as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one)

State Registrar

29b. Signature and title of certifie

Baltimore, Maryland 21215-0036

Box 68760

P.O. P

Division of Vital Records,

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D003325U

29d. Date signed (Month, Day, Year)

Cumberland, MD 21502

1 - For State Registrar 1. Decedent's Name (First, Middle, Last)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

| J | 9.0 | (7) | $\cap$ | $\cap$ | - |
|---|-----|-----|--------|--------|---|
|   | Reg | Ner | U      | U      | U |

2. Date of Death

22544

3. Time of Death

| ဖွ          |  |
|-------------|--|
| 121215-0036 |  |
| nd 212      |  |
| Maryland    |  |
| altimore,   |  |

Bush, Willie Ida

P.O. Box 68760 Division of Vital Records, Hospital or Attending Physician:

Month **Physician** Willie Ida Bush 11:40 P M 28 June 2006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince Doctor's Community Hospital Lanham Georges If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🕏 F 85 578-42-5225 05-21-1921 Director No.Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hem 27 is marked other then "natural", or Rema 23e or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1816 Independence Ave., S.E. 20003 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Black Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then 'eny injury or other traumatic event, Lim Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Caregiver Private Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Dorhman Priscilla Neal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2503 Fire House Road 19a. Informant's Name/Relationship (Type, Print) Barbara Lee (Daughter) Landover, Maryland
Place of Disposition (Name of cemetery, crematory or other place) 20785 20c. Location - City or Town, State 20b. Place 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Harmony Mem. Park 07-05-06 Landover, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ralph Williams Funeral Service 1813 Potomac Ave., SE; Wash., D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20003 Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician erebyal /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number MDD 45660 of person who completed cause of deam (Item 23a) (Type, Print) 30. Name and address Ballant Fox Ln, Ste 124 Bowie, MD 20715 31. Date filed (Month, Day, Year) State 0 3 2006 Registrar

|                            |  | •                | For<br>State<br>Registrar   | State of Mary   |                         |                       | nt of He<br>te of D      |                             | nd M     | -                              | giene<br>Reg. No. ( | 2006                             | 22545  |
|----------------------------|--|------------------|---|---|-------------------------|-----------------------|--------------------------|-----------------------------|----------|--------------------------------|---------------------|----------------------------------|--|
|                            |  |                  | Decedent's Name (First, Middle, La.   | st)   |                         |                       |                          |                             |          | 2. Date of De.                 |                     |                                  | 3. Time of Death                               |
|                            | Physicia   |                  | Leroy Schaeffer   | Rremerman.  | .Ir.                    |                       |                          |                             |          | June 2                         | 9. 20               | Year<br>106                      | 11:10 a <sup>M</sup>                           |
|                            | /Medic<br>Examin   |                  | 4a. Facility Name (If not institution, giv  |   | 011                     | 4b. City              | , Town, or               | Location of                 | Death    |                                |                     | ounty of Death                   |  |
|                            |  | er               | Stella Maris Hos  |   |                         | Т                     | imoni                    | 11m                         |          |                                | Ba 1                | timore                           |  |
|                            | Funeral  |                  | 5. Social Security Number 6. S  |   | yrs. last birthday)     | If Unde               | r 1 Year                 | If Under 24                 |          | 8. Date of Birt                | th                  | 9. Birthp                        | lace (State or Foreign                         |
| н                          | Director   |                  | 216-30-4201   | ⊠M 2□F 72   | Yrs.                    | Months                | Days                     | Hours                       | Min.     | (Month, Da<br>2/20/19          |                     | Co <i>u</i> n<br>Washi           | ngton, DC                                      |
|                            |  |                  | Usual Residence of Decedent   |   |                         |                       | · · · · · ·              |                             |          | -7-07-2                        |                     |                                  |  |
|                            | ylan<br>how  |                  | 10a. State 10b. County  |   | c. City, Town or L      |                       |                          |                             |          |                                |                     | 1                                | Od. Inside City Limits                         |
|                            | Ma-f   | Ş                | Maryland Prince   | George's  | College                 | Par                   | k                        |                             |          |                                |                     |                                  | 1X Yes 2 No                                    |
|                            | h the  | ire              | 10e. Street and Number  |   |                         | 10f. Z                | p Code                   |                             |          |                                | 10g. Citize         | n of What Cour                   | itry?  |
|                            | th wit   | Funeral Director | 3501 Metzerott  | Road  |                         |                       | 2074                     | 10                          |          |                                |                     | USA                              |  |
|                            | dea<br>m   | ner              | 11. Marital Status  | 12. Was Decedent Ever<br>Armed Forces?  | in U.S. 13.<br>L956-    | Was Dec               | edent of His             | spanic Origi<br>n. Mexican. | in? (Spe | cify Yes or No<br>Rican, etc.) | - 14                | . Race - Americ<br>Black, White, |  |
| 9                          | or It  | 2                | 1 ☐ Never Married 2X Married  | 1 FFIYes 2 □ No 1   | 1962                    | 1 ☐ Yes               |                          | Specify:                    |          |                                |                     |                                  | ite  |
| 21215-0036                 | 72 hours after death with the Maryland<br>natural; or Iteme 23a or 28a-f ehow<br>alcal Examinat must be notified at  | d by             | 3 Widowed 4 Divorced  | Year or Dates:  |                         |                       |                          |                             |          |                                |                     |                                  |  |
| 5-                         | 72 h   | Completed        | 15. Decedent's E<br>(Specify only highest gra   |   | (Give                   | kind of w             | ual Occupa<br>ork done d | uring most of               | of worki | ng                             | 16b. Kind           | of Business/Inc                  | dustry   |
| 2                          | han han  | d l              | Elementary/Secondary (0-12)   | College (1-4or 5+)  | iire.                   | Sale                  | use retired)             |                             |          |                                | ۸۳۵                 | hway                             |  |
| 2                          | led w<br>lygie<br>her ti<br>nt, th   | ပိ               | 12 17. Father's Name (First, Middle, Last   | 1   |                         | Sale                  |                          | 19 Mothor                   | 'e Namo  | (First, Middle,                |                     |                                  |  |
| E C                        | be fi  | Be               | Leroy S. Bremen   |   |                         |                       |                          |                             |          | Donovan                        |                     | amame)                           |  |
| 3                          | ould<br>Mer<br>narke   | ٥                |   |   | 405 14-11               |                       | (0)                      |                             |          |                                |                     | Faura Chada 7ia                  | Code   |
| Maryland                   | and rem  | - 1              | 19a. Informant's Name/Relationship (  |   |                         | -                     |                          |                             |          |                                |                     | Town, State, Zip                 | 740  |
| ď,                         | l and<br>Health<br>im 27   |                  | Barbara A. Bremen   |   | 0b. Place of Disp       |                       |                          | L Kd.                       |          | ollege                         |                     | tion - City or To                |  |
| ō                          | t of t   |                  | 1 ☐Burial 2 ☐ Cremation 3 ☐   | Removal from State  | cemetery, cre           | matory or             | other place              |                             |          |                                |                     |                                  |  |
| Ë                          | Pa<br>tmen<br>tant:  |                  | 4 □ Donation 5 □ Other (Special   |   | Ft. Linco               |                       |                          | -                           |          | 2006                           |                     |                                  | Maryland                                       |
| Baltimore,                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. Important: If them 27 is marked other than "natural", or Iteme 23a or 28a-f show eny Injury or other traumatic event, to Medical Examinat must be notified at once. |                  | 21. Signature of Funeral Service Lies   | 77/0  |                         |                       |                          | s of Facility               | Gai      |                                |                     | 1 Home,                          |  |
|                            | 40 = 0   |                  | Kollett (   | 1/29  | 4                       | 739 E                 | altin                    | nore A                      | ve.      | , Hyatt                        | svill               | e, MD                            | 20781<br>Approximate                           |
|                            |  |                  | 23a. Part . Enter the disease, or com<br>shock, or heart failure. List only                                 | one cause on each line.   | death. Do not en        | iter the mo           | ae or ayıng              | g, such as c                | ardiac   | r respiratory a                | rrest,              |                                  | Interval Between<br>Onset and Death            |
| 1                          | Physician  |                  | Immediate Cause (Final disease of condition   | A NON SMALL   | CELL LU                 | NG CA                 | NCER                     |                             |          |                                |                     |                                  |  |
|                            | /Medical<br>Examiner   |                  | resulting in death)   | Due to (or as a co  | nsequence of):          |                       |                          |                             |          |                                |                     |                                  |  |
|                            | LXdiffiller  | L                | Sequentially list conditions,   | b. Due to (or as a co   |                         |                       |                          |                             |          |                                |                     |                                  |  |
|                            | sit ad   | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a co  | risequerice oi).        |                       |                          |                             |          |                                |                     |                                  |  |
|                            | and<br>I-tran  | Examin           | that initiated events resulting in death) Last  | cDue to (or as a co   | nsequence of):          |                       |                          |                             |          |                                |                     |                                  |  |
| 8760,                      | certificate be executed iding physicien and ise as the burial-transit  | <u>=</u>         |   | 220 10 (0) 10 0   |                         |                       |                          |                             |          |                                |                     |                                  |  |
| 87                         | phys<br>the  | dicai            | •   | _ d   |                         |                       |                          |                             |          |                                |                     |                                  |  |
| 9<br>X                     | eath certifica<br>attending ph<br>I for use as th  | Physician/Me     | IF FEMALE:  | 23c. If yes, outcome of p   | regnancy                |                       | ·                        |                             |          |                                |                     | d. Date of delive                |  |
| Box                        | death of attended for up   | ian              | 23b. Was decedent pregnant in the past 12 months?   | 1 ☐ Live birth 2 ☐<br>4 ☐ Pregnant at time                                    | Fetal death 3           | □Ectopic<br>□ Other ( | pregnancy                |                             |          |                                | 23                  | Month                            | Day Year                                       |
|                            | the de   | ysic             | 1 □ Yes 2 □ No<br>9 □ Unknown   | 9□ Unknown  | or ddawr                | _ 0.000 (             |                          |                             |          |                                |                     |                                  |  |
| P.O                        | that the deed by the detached  | P.               | Part II. Other significant conditions   | contributing to death but no  | ot resulting in the     | underlying            | cause give               | en in Part I.               |          | 23e. Did t                     | obacco use          | contribute to the                | ne cause of death?                             |
| Division of Vital Records, | 9 P 9  | d by             |   |   |                         | , -                   |                          |                             |          | 1 🗆                            | Yes 2□              | No 3 □ Prot                      | ably 4X Unknown                                |
| Ö                          | w requir<br>been si<br>should  | Completed        |   |   |                         |                       |                          |                             |          | 240 1450                       |                     | Odb Mass sub-                    | seu findless avallable                         |
| ě                          | 2 8 8  | id               |   |   |                         | <del></del>           |                          |                             |          | 24a. Was                       | psy<br>ormed?       | prior to co<br>death?            | psy findings available<br>mpletion of cause of |
| =                          | T ate  | S                |   | 1   |                         |                       |                          |                             |          | 1 ☐ Yes                        |                     |                                  | 2□ No  |
| /ite                       | Physicien: Th<br>this certificate<br>ral director, pag   | Be               | 25. Was case referred to medical examiner?  | Hospital:   |                         |                       | Ctho                     |                             |          | Check only                     |                     |                                  |  |
| 5                          | Physic<br>this c   | ၉                | 1 ☐ Yes 2 📉 No  | 1 inpatient   | 2 ER/Outpatie           |                       |                          |                             |          |                                |                     |                                  | W HOSPICE                                      |
| Ĕ                          | Mite   | on               | 27. Manner of Death 1 XNatural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Ye   | ar) 28b. Time (         |                       | 28c. Injury<br>Work      |                             |          | 28d. Describe                  | now injury          | occurred                         |  |
| sio                        |  | cat              | 2 Accident investigation 3 Suicide 6 Could not t  | 30  | AA h a = = - 40 = = = - | M                     |                          | Yes 2□N                     |          | 20f Location (                 | Ctroot and          | Alumbor or Pum                   | al Route Number.                               |
| Ξ                          | or Al  | Certification:   | 4 Homicide determined   | 28e. Place of Injury -<br>building, etc. (S                                   | Specify)                | treet, facto          | огу, опісе               |                             |          | City or To                     |                     | TValliper of Flare               | arrioute Number,                               |
|                            |  | S                | COn Continue of Continue  | hydiology To the format   | u kanudada - d          | th a                  | d at the F               | o data and                  | d place  | and due to the                 | QQUee/-1            | nd manas:                        | tatod  |
|                            | Hospital<br>24 hours (Funeral I  | edical           | (Check only 2 Medical Exa   | hysician: To the best of m<br>minar: On the basis of exa<br>and manner stated | amination and/or i      |                       |                          |                             |          |                                |                     |                                  |  |
|                            | To the Hos<br>within 24 h<br>To the Fur<br>completely  | Med              | one) 29b. Signature and title of certifier  | and manner stated   |                         | 2                     | 9c. License              | number                      |          |                                | 29d, Date           | signed (Month,                   | Dav. Year)                                     |
|                            | 5 × × 5 0  | _                | 250. Signature are title of Certified   |   |                         | -                     |                          | 377                         | 7 ~      |                                |                     |                                  |  |
| _                          | 0  |                  | / 0, , , , , , , , , , , , , , , , , , ,  |   |                         |                       | 1                        | 211                         | C 7      |                                | 4                   | 124/0                            | 16   |
| 1)                         | 110 1111   | Į.               |   |   |                         |                       |                          |                             |          |                                |                     |                                  |  |
| 1                          | (10/IV)  |                  | 30. Name and address of person who  |   |                         |                       | ם מכ                     | ртилатт                     | TIME T   | VID 2100                       | 2                   | /                                |  |
| 1                          | (0) Va   |                  | DR. TARIQ MAHMO  31. Date filed (Month, Day, Year)  |   | ANEY VAL                | LEY I                 | D. 7                     | IMONI                       | CUM,     | MD 2109                        | 3                   |                                  |  |

DHMH 17 Rev 1/2001

JUNE 29, 2006 11:10 a.m.

LEROY BREMERMAN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2006 8:22 a.m. Jr. Ju<sub>1</sub>y Brong, Andrew /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Hollywood 25508 Jones Wharf Road 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months **№** M 2 F Yrs 5, 1918 Director Pennsylvania 203-01-4641 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20636 United States 25508 Jones Wharf Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

¹X Yes 2 □ No
If Yes, Give
Year or Dates:1941 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or iteme 11. Marital Status filed within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 'naturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Air Craft Mechanic US Navy 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H lant: If item 27 is marked other. Ervin Andrew Brong, Sr. Frances Ollendick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25508 Jones Wharf Road Hollywood, Maryland 20636 nt of Health a : If item 27 is or other tra Stella S. Brong / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Jul.10,2006Great Mills, Maryland Evergreen Memorial 4 ☐Donation 5 ☐ Other (Specify) 21. Sing uneral Septe Dicenses Laward N. Brinsfield M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final heart failure weeks Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coroner artery drsage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner and I-transit The law requires that the death certificate be executed cerebro valcular disease that initiated events resulting in death) Last Due to (or as a consequence of) inding physicien a Division of Vital Records, P.O. Box 68760. diabetes Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA After the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 € Certifying Physician: To the best of my knowledge, death conumed at the time, date and place, and due is the cause(s) and memor as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D42597 **7-7-06** 26840 Point Lookout Road 30. Name and porress of person who completed cause of death (Item 23a) (Type, Print)

Teffrey C. Brown frey C. Brown, wo Leonardtown, Maryland 20650 31. Date filed (Month, Dav. Year) State 1 0 2006 Registra

James Irving Brooks, Jr.

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

|  |               | 1- For State<br>Registrar  |                                 | Cer                        | tificate of       | Death                                     |                   | F                                       | Reg. No.          | 000   |
|--|---------------|--|---------------------------------|----------------------------|-------------------|---|-------------------|---|-------------------|---|
| Physici  | أسند          | 1. Decedent's Name (First, Midd  | Month Day Year                  |                            |                   |   |                   |   |                   |   |
| ledical Exam   | ner           | James  | I.                              | brooks,                    | Jr.               |   |                   | July 9, 20                              | 06 YE             | 0436 hrs  |
|  |               | 4a. Facility Name (if not institution  | in, give street and n           | umber)                     | 4                 | b. City, Town, or L                       |                   | eath                                    | 4c. County        | of Death  |
|  |               | Calvert Memorial Hos   | pital                           |                            |                   | Prince Frede                              | rick              |   | Calvert           |   |
| Funeral  |               | 5. Social Security Number  | 6. Sex                          | 7 Age (In yrs la           | ast birthday)     | If Under 1 Year                           | If Under 24       |   | rth (MM/DD/YYY    | Y) 9 Birthplace (State or   |
| Director   |               | 212-02-0229  | 1X M 2 F                        | 25                         | Yrs               | Months Days                               | Hours             | Jan. 2                                  | 7,1981            | Foreign<br>Magarnyyland   |
| -  |               | Usual Residence of Decedent  |                                 | l                          |                   | <del></del>                               | <u> </u>          |   | , ,               | 7 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 -                                 |
| any  |               | 10a State 10b. County  |                                 | 10c. City,                 | Town or Location  | on  |                   |   |                   | 10d. Inside City Limits   |
| *  |               | Maryland Ca  | lvert                           |                            | Pri               | nce Fre                                   | dari              | ck                                      |                   | 1 Yes 2 X No  |
| Maryland<br>28a-f show<br>d at once.   | Ş             | 10e. Street and Number   |                                 |                            | 111               | 10f. Zip Code                             | -der I            |   | 10g. Citizen of W | 71  |
| r 28a  | Director      | 5430 Macs Ho   | 11 ov Ro                        | a d                        |                   | 20678                                     | 2                 |   | USA               | what Godnity !  |
| th the<br>23a o<br>19tifi  |               |  |                                 |                            |                   |   |                   |   |                   |   |
| h wil<br>ems   | Funeral       | 11. Marital Status   | 12. Was De                      | cedent Ever in U           |                   | Decedent of Hispa<br>es, specify Cuban, I |                   |   |                   | e - American Indian, Black,<br>te, etc.                                 |
| deat or its  | -u-           | 1 X Never Married 2 M  |                                 | Forces?                    |                   |   |                   | , | ŀ                 |   |
| after<br>'all',  | by I          |  | orced If Yes, Give Ye or Dates: |                            |                   | Yes 2 X No                                |                   |   |                   | Black   |
| ours<br>natur  |               | 15. Decedent's Education (Spe  |                                 |                            |                   | 's Usual Occupationst of working life. [  |                   |   | 16b. Kind of B    | usiness/Industry  |
| 6<br>72 h<br>nn °r   | Completed     | Elementary/Secondary (0-12)  | College (                       | 1-4 or 5+)                 | Commur            | ication                                   | is Tec            | chnicia                                 | n Commi           | unications  |
| 036<br>vithin 73<br>ene.<br>er than  | ᇤ             | 12   |                                 |                            |                   |   |                   |   | .)                |   |
| 215-0036<br>be filed within 7<br>ntal Hygiene.<br>rked other than<br>ent, the Medica   | ပိ            | 17. Father's Name (First, Middle   | ,                               | _                          |                   | 18  | B.Mother's Na     | me (First, Middle,                      | Maiden Surnami    | e)  |
| 21215-003<br>uld be filed withi<br>Mental Hygiene.<br>marked other tt  | Be            | James I.   | Brooks                          | , Sr.                      |                   |   | Dar1e             |   |                   | ite   |
| D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiens of 1°s marked other than "natural", or items 23a or 28a-f sho ratic event, the Medical Examiner must be notified at once | 잍             | 19a Informant's Name/Relations   |                                 | _                          |                   |   |                   |   |                   | wn, State, Zip Code)  |
| MD 2 shouth and 27 is a  |               | Darlene A. B   | rooks/m                         | other                      | 5430              | Macs Ho                                   | ollow             | Rd. Pr                                  | ince Fi           | red.,MD 20678   |
| ore, ME<br>es 1 and 2 s<br>of Health at<br>If item 27<br>her traums  |               | 20a Method of Disposition  |                                 |                            | Place of Disposi  | tion (Name of ceme                        | etery,            | Date                                    | 20c. Location     | - City or Town, State   |
| imore, MD 21215-0036  Pages I and 2 should be filed within 72 hou ment of Health and Mental Hygiene.  Fami. If item 37 is marked other than "nan or other traumatic event, the Medical Exp                             |               | 1 X Burial 2 Cremation   |                                 |                            |                   |   | m   7             | /15/2006                                | Drine             | ce Fred., MD  |
| altimore, MD rmit. Pages I and 2 sho spartment of Health and pportant: If item 27 is jury or other traumati  |               | 4 Donation 5 Other S<br>21. Signature of Funeral Service   | Decify:                         | - Cu                       | 122 N             | ame and Address of                        | of Eacility -     | 13/2000                                 | 7 1 1 1 11 (      | e ried., mb   |
| Baltimo<br>permit. Page<br>Department of<br>Important:<br>injury or oft  |               | DO - 1   | ν.                              | 1                          | 1 /               | 51 Doro                                   | Se                | ewell F                                 | uneral            | Home<br>Fred.,MD2067  |
|  | - 1           | 23a. Part I. Enter he disease, or  | Sewelf                          | raused the death           | Do not enter th   | e mode of dying si                        | uch as cardia     | CII NU. I                               | rest shock or he  | eart Approximate Interval   |
| Physician<br>/Medical  |               | failure. List only one cause   | on each line.                   |                            |                   |   |                   |   |                   | Between Onset and   |
| Examiner   |               | Immediate Cause (Final disease   |                                 |                            |                   | 1cohol and                                | Phencyc           | lidine use                              |                   | Death   |
|  |               | or condition resulting in death)   | Due to (or as                   | a consequence of           | f).               |   |                   |   |                   | 1   |
|  | ايز ا         | Sequentially list conditions, if any, leading to immediate   | b.                              | a consequence of           | f\.               |   |                   |   |                   |   |
|  | aminer        | cause. Enter Underlying Cause  |                                 | a consequence of           | 17.               |   |                   |   |                   |   |
| 1  | кап           | (Disease or injury that initiated events resulting in death) Last  | Due to (or as                   | a consequence of           | f):               |   |                   |   |                   |   |
| cuted<br>nd<br>transi  | I Ex          |  | d                               |                            |                   |   |                   |   |                   |   |
| 8760, rificate be executed ng physician and as the burial - transit as the burial - transit  | dical         | X UNPENDED   | AMENDED                         | item#23a                   | ,27,28a-f         | ,perME,g857                               | 7 <b>,</b> 7/24/0 | 6 TT                                    |                   |   |
| 8760,<br>tificate be er<br>ng physiciar<br>as the burial   | n/Mec         | IF FEMALE.   | 23c. If yes                     | outcome of pregr           | nancy             |   |                   |   | 23d Date o        | of delivery   |
| 8 = = 0  | l/ue          | 23b. Was decedent pregnant in the past 12 months?  | ne 1 Live                       | birth                      | 2 Fet             | al death 3                                | Ectopic pre       | gnancy                                  | Month             | Day Year  |
| th cer<br>trendi   | ici           |  |                                 | nant at time of de         | ath 5 Oth         | er (Specify)                              |                   |   |                   |   |
| Box 68 te death cert the attendir red for use a  | Physicia      |  | known 9 Unkr                    |                            |                   |   |                   |   |                   |   |
| - + > 5  | by P          | Part II. Other significant condi-  | ions contributing               | to death but not re        | esulting in the u | nderlying cause giv                       | en in Part I      |   |                   | ribute to the cause of death?   |
| rds, P.O requires that been signed b   |               |  |                                 |                            |                   |   |                   | _ 1 Ye                                  | s 2 <b>V</b> No 3 | Probably 4 Unknown  |
| ords, w requires been should   | ompleted      |  |                                 |                            |                   |   |                   | 24a Was<br>auto                         |                   | Were autopsy findings available prior to completion of cause of         |
| e law<br>e has<br>ge 2 s   | ᇤ             | · · · · · · · · · · · · · · · · · · ·  | <del> </del>                    | <del> </del>               |                   |   |                   | perfo                                   | rmed?             | death?  |
|  | ပိ            | 25. Was case referred to medical   | . 1                             |                            |                   | 00 01                                     | (D. alb. (Ob.     | 1 Yes                                   | 2 No 1            | Yes 2 No  |
| on of Vital Records, ending Physician: The law requir path or: After this certificate has been so the funeral director, page 2 should I  | Be            | examiner?  | Hospital:                       | 1                          | EDIO IL III       |   | ther, Nu          |   |                   |   |
| f Çir<br>Physic<br>er this   | ျ             | 1 Yes 2 No<br>27. Manner of Death  | - '- '-                         | Inpatient 2 🗸              |                   | O DOA                                     | - ING             | rsing Home 5                            | Residence 6       | Other:  |
| <b>-</b> = _ ` =   | i.            | 1 Notural  | (Mon                            | h, Day,Year)               | 28b. Time of Ir   |   |                   |   | how injury occur  | rea   |
| SiOF<br>ttenk<br>death<br>rtor:<br>y the   | atic          | The state of the s | Sugation                        | 7/9/2006                   | Fnd 3:34          |   | s 2 No            | subject                                 |                   |   |
| Division tal or Attendi rs after death al Director: A  | ertification: |  | la not be                       |                            | ome, farm, stree  | t, factory, office bui                    | ilding, etc       | 28f. Location (                         | Street and Numb   | per or Rural Route Number, City<br><b>hristiana Parran</b><br><b>MD</b> |
| Divipital or ours after the Divipital or fittleer all Divipital or fittleed in   | Cer           | 4 Homicide   | rmined (Specify                 | Pool                       |                   |   | -                 | Chesapea                                | ke Beach,         | MD  |
| 1 los<br>24 h<br>Film<br>etely   |               |  | hysician: To the be             |                            |                   |   |                   |   |                   |   |
| Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the   | Medical       | one) 2 Medical Exa   | miner: On the basis             | of examination a<br>stated | nd/or investigati | on, in my opinion, o                      | death occurre     | ed at the time, date                    | and place, and    | due to the cause(s)   |
| <b>⊢</b> 3 <b>⊢</b> 3  | ¥ e           | 29b. Signature and title of certifi  |                                 |                            |                   | 29c License                               | number            |   | 29d Date sign     | ned (Month, Day, Year)  |
|  |               | MIOTO  |                                 |                            |                   | O.C.M                                     | .E.               |   | July 10, 20       | 006   |
|  |               | 30. Name and address of persor   | who completed car               | use of death (Item         | 23a)              |   |                   |   |                   |   |
| _  |               | · ·  | sistant Medical                 |                            |                   | treet, Baltimor                           | e, MD 212         | 201                                     |                   |   |
|  | tate          |  |                                 |                            |                   |   |                   |   |                   |   |
| S<br>Regis   | tate          | 31. Date filed (Month, Day, Year)  | 4 2006                          | strar's Signatu            | K Ka              | ask o                                     |                   |   |                   |   |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date Month 3, 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Lawrence S. Best July 2006 2:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 123 Sea Breeze Dr., Ocean City Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 526-09-8340 Feb. 92 Director 1914 Texas Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or Iteme 23a or 28a-1 ehow the Madical Examiner must be notified at 1 X Yes 2 □ No Director MD Worcester Ocean City 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 123 Sea Breeze Dr. 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Maryland 21215-0036 Specify White 1 ☐ Yes 2 ☒ No Specify. <u>ک</u> 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Contractor Building 5 4 1 permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Importent: If Item 27 1e marked othe any Injury or other traumatic event, philes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel S. Best Magdelena Varela 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda Miller (daughter) 512 Adelaide La., Bel Air, Md. 21015 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cape Henlopen Crem. 7-3-2006 Frankford, DE of Fune Service License 22. Name and Address of Facility The Purhage Funeral Home 108 William St., Berlin, Md. 21811 art1. Enter the disease, or complications that can shock, or heart failure. List only one cause on east ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, i line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardio pulmonary Collapse /Medical Due to (or as a consequence of): Examiner Heart condition 6-12 months Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Heart murmur 6-12 months attending physician and for use as the burial-tran-Due to (or as a consequence of): Box 68760, Physician/Medical Lung Mass 2-4 months IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death P.O. 1 signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by been significant Being evaluated for possible lung cancer 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 Yes 2 No 1 Yes 2 No or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 ☐ Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1X Certifying Physician: To the basis of my knowledge ideath occurred at the time, date and place and due to the cause(s) and no more as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the I 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) of certifier D40836 7-6-2006 who completed cause of death (Item 23a) (Type, Print) BA 10+1 Thomas B. Fioretti, M.D. 13111 Coastal Hwy., Ocean City, Md. 21842 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUL 0 6 2006

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Thomas Franklin Burroughs Julu 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death PENINSULA REBIONAL MEDICAL CENTER Hicomic SALISBUR If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1**X** M 2□ F Hours Min 229-54-1872 63 12/29/1942 V٨ Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10135 Mason Rd. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 XMarried 1 Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Plumbing <u>Master Plumber</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Augustus Burroughs Julia Custis Mister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freeda C. Burroughs (wife) 10135 Mason Rd., Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Sunset Memorial Park 7/6/2006 4 ☐Donation 5 ☐Other (Specify) Berlin, MD 21. Signature of uneral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 wha 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 22 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred **Natural** 5 Pending investigation 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner the death certificate be executed Box 68760. ے

**Physician** 

/Medical

Examiner

Director MD

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**Funeral** 

Director

r than "natural", or Iteme 23s or 28s-f ehow the Medical Examiner must be notified at

be filed within 72 hours a lal Hygiane. d other than "natural", o

2 should be f and Mental h is marked

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
eny Injury or other trau

**Physician** 

burial-transit and

ng physician a

Physician/Medical

3

Completed

Certification:

Medicai

29a. Certifier (Check only 29b. Signature and title

30. Name and adds

Maryland 21215-0036

Baltimore,

signed by the attending the detached for use as o Records. has of Vital After this certific funeral director, Division death. al or Attend efter death f Director: / filled in by To the Hoepital o within 24 hours eff To the Funeref DI completely filled in

State Registrar

DHMH 17 Rev 1/2001

onth, Day, Year) 31. Date filed (Mg 6

s of person who completed o

60

suse of death (Item 23a) (Type, Print)

On SAUSBUR

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

019932

29d. Date signed (Month, Day, Year)

|                            |  |                   | 1 - For<br>State<br>Registrar AMEND#19bperFH                                  | State of Maryland   |                 | artment of H                            |   |                                   | iene 200 (                         | 22550  |
|----------------------------|--|-------------------|---|---|-----------------|---|---|-----------------------------------|------------------------------------|--|
|                            |  | <i>\$.</i>        | Decedent's Name (First, Middle, Last)   |   |                 |   |   | 2. Date of Deat                   | h                                  | 3. Time of Death                                     |
|                            | Physici  | -                 | Mildred B. Burt   | on  |                 |   |   | July 4                            | 1, <sup>Day</sup> 2006 Year        | 1:50 a M   |
| 15                         | /Medio   | war               | 4a. Facility Name (If not institution, give s                                 | street and number)  |                 | 4b. City, Town, o                       | r Location of Death                         |                                   | 4c. County of De                   | ath  |
|                            | Examir   | ier               |   |   |                 | 015077                                  |   |                                   | 26                                 |  |
| 30                         | Funeral  |                   | Montgomery Genera 5. Social Security Number 6. Sex                            |   | ast birthday)   | Olney<br>If Under 1 Year                | If Under 24 Hrs.                            | 8. Date of Birth                  | 9. B                               | tgomery<br>inthplace (State or Foreign               |
|                            | Funeral Director   | П                 | 10  | M 2 F   | Yrs.            | Months Days                             | Hours Min.                                  | (Month, Day,<br>Oct. 10           |                                    | Ohio   |
|                            | 75   |                   | 577-24-2416 Usual Residence of Decedent                                       | 82  |                 |   |   |                                   |                                    | 0.1.10   |
|                            | ylan   |                   | 10a. State 10b. County  | 10c. City   | , Town or Lo    | ocation                                 |   |                                   |                                    | 10d. Inside City Limits                              |
|                            | Ma-1-8   | to                | Maryland Montgo   | mery Silv   | er Spi          | ring                                    |   |                                   |                                    | 1 ☐ Yes 24 ☐ No                                      |
|                            | n the  | Director          | 10e. Street and Number  | tr. 11 D1 1   |                 | 10f. Zip Code                           | 6   | 1                                 | 0g. Citizen of What                | Country?   |
|                            | 23a c  |                   | 3497 South Leisu  | re world blvd   | •               | 2090                                    | 6   |                                   | USA                                |  |
|                            | dea  | Funerai           | 11. Marital Status  | 12. Was Decedent Ever in U.<br>Armed Forces?                  |                 | Was Decedent of H                       | lispanic Origin? (St<br>an, Mexican, Puerto | pecify Yes or No-<br>Rican, etc.) | 14. Race - An<br>Black, Wh         | nencan Indian,<br>nite, etc.                         |
| 9                          | or Ite   |                   | 1 Never Married 2 Married   | 1 Yes 2 No  | 1               | 1 ☐ Yes 2 ☒ No                          |   | ,                                 | Specify:                           |  |
| 21215-0036                 | iral',   | d by              | 3 ☑ Widowed 4 ☐ Divorced  | Year or Dates:  |                 |   |   |                                   |                                    | White  |
| ,                          | 72 h<br>'natu  | Completed         | 15. Decedent's Edu<br>(Specify only highest grade                             | cation<br>completed)  | (Give           | dent's Usual Occup<br>kind of work done | during most of world                        | king                              | 16b. Kind of Busines               | s/Industry   |
| 2                          | Athin<br>Pan<br>Pan  | Idm               | Elementary/Secondary (0-12)   | College (1-4or 5+)  |                 | DO NOT use retire<br>emaker/Co          | ,   |                                   | rm Homo/I                          | andscaping   |
| 7                          | filed within 72 hours after death with the Maryland<br>Hygiene.<br>sther than "natural", or Itema 23a or 28e-f show<br>snt, the Masical Examiner must be meilified at  | ပိ                | 17. Father's Name (First, Middle, Last)                                       |   | 1101116         | emaker/co                               |   | ne (First, Middle, M              |                                    | andscaping   |
| no                         | be fi  | Be                | Grant Beattie   |   |                 |   |   | ine Wiand                         |                                    |  |
| Maryland                   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-1 show mary inject or jets the traumatic event, the Macified Examiliter man be notified at once. | 10                |   | no Deine)   | 10h Maili       | an Address (Ctract                      |   |                                   | , City or Town, State              | Zin Codo)  |
| ā                          | 12 st  | 1                 | 19a. Informant's Name/Relationship (Ty  |   |                 |   | Port  | 250                               |                                    |  |
|                            | 1 and<br>Health<br>em 27<br>ther tr  |                   | Charles R. Burton   |   |                 | L Elder R  osition (Name of             |   | -                                 | MD 2067<br>20c. Location - City of |  |
| Ö                          | Pages I  |                   | 20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ R                    | emoval from State   | emetery, cre    | matory or other pla                     | ce) Ju                                      | ly 8,                             | 200. Location - Oity C             | i rowii, State                                       |
| <u>ٿ</u>                   | tant:  |                   | 4 □ Donation 5 □ Other (Specify)  |   |                 | ncoln Cem                               |   |                                   | Brentwood,                         | Maryland   |
| Baltimore,                 | Departr<br>Departr<br>Importe<br>any Inju  |                   | 21. Signature of Funeral Service License                                      |   | Fi              | ancis Addre                             | sscollins                                   | Funeral                           | Home Inc                           |  |
| _                          | 905 e a  |                   | (mchew)   | tole  |                 |   |   |                                   |                                    | g ,MD 20901  |
|                            |  |                   | 23a. Part1. Enter the disease, or compleshock, or heart failure. List only or | cations that caused the death<br>e cause on each line.        | n. Do not en    | ter the mode of dyi                     | ng, such as cardiac                         | or respiratory arre               | est,                               | Approximate<br>Interval Between<br>Onset and Death   |
|                            | Physician  | 6 6               | Immediate Cause (Final disease or condition                                   | Strok   | P               |   |   |                                   |                                    | Orisot and Death                                     |
|                            | /Medical   |                   | resulting in death)   | Due to (or as a consequ                                       | uence of):      | NII. 1                                  | r   |                                   |                                    |  |
|                            | Examiner   |                   | Sequentially list conditions  | ATMOL   | FIV             | 2 11 CC-1                               | 101   | _1101                             |                                    |  |
| 150                        | p #  | Examiner          | Sequentially list conditions, cause. Enter Underlying                         | Due to or as a consequ  | uence of:       |   |   |                                   |                                    |  |
|                            | ecute<br>ind<br>trans  | am                | Cause (Disease or injury that initiated events resulting in death) Last       |   |                 |   |   |                                   |                                    |  |
| Ö,                         | ate be executed hysician and the burial-transit  |                   | resulting in ceatily cast   | Due to (or as a consequ                                       | ience of):      |   |   |                                   |                                    |  |
| 8760,                      | ate<br>by  | Physician/Medical |   |   |                 |   |   |                                   |                                    |  |
| မ                          | eath certific<br>attending pl  | Med               | IF FEMALE:  |   |                 |   |   |                                   |                                    |  |
| Вох                        | death certific<br>e attending p<br>id for use as   | an/               | 23b. Was decedent pregnant in the past 12 months?                             | 3c. If yes, outcome of pregna<br>1 ☐ Live birth 2 ☐ Fetal     | death 3         | Ectopic pregnanc                        | у   |                                   | 23d. Date of d<br>Month            | elivery<br>Day Year                                  |
| В                          | e dea<br>he at<br>ed fo  | sici              | 1 ☐ Yes 2 No  | 4☐Pregnant at time of de<br>9☐Unknown                         | eath 5[         | Other (specify)                         |   |                                   | 10.000                             | July 104   |
| <u>a</u>                   | that the de<br>led by the a<br>detached f  | Phy               | 9 Unknown   |   | Maria a Caraba  |   | . C. D. Al                                  | 22a Did tak                       | and was contabute                  | to the equal of death?                               |
|                            | 89 D G   | b                 | Part II. Other significent conditions con                                     | ntributing to death but not rest                              | liting in the u | inderlying cause giv                    | ven in Part I.                              |                                   | A                                  | to the cause of death?  Probably 4 Unknown           |
| b                          | w requir<br>been si<br>should  | Completed         |   |   |                 |   |   | 1 □ Ye                            | 3 2 3 1                            | - Tobably 4 Donkhown                                 |
| ပ္ပ                        | e law r<br>has be<br>ge 2 sh   | ple               |   |   |                 |   |   | 24a. Was a autops                 | n 24b. Were                        | autopsy findings available<br>completion of cause of |
| <u>~</u>                   | The Tate has page  | Ю                 |   |   |                 |   |   | perform                           | ned? death'<br>2 No 1 ☐ Ye         |  |
| ita                        | ician: Th<br>certificate<br>ector, paq   | Be                | 25. Was case referred to medical  |   |                 |   | 26. Place of Dea                            | th (Check only on                 | θ)                                 |  |
| <b>/</b>                   | Physician:<br>this certific<br>al director,  | To E              | examiner?   | lospital: Inpatient 2   | ER/Outpatie     | nt 3□ DOA Ott                           | ner: 4 🗆 Nursing H                          | ome 5 Reside                      | ence 6 Other (Sp                   | pecify)  |
| 0                          | ding Ph<br>h.<br>After th<br>funeral   |                   | 27. Manner of Death  Hatural 5 Pending  | 28a. Date of Injury<br>(Month, Day Year)                      | 28b. Time o     | 1 28c. Inju<br>Wo                       | ry at<br>rk?                                | 28d. Describe ho                  | w injury occurred                  |  |
| <u>.</u>                   | Attending r death. ector; After oy the fune  | atic              | 2 ☐ Accident investigation  |   | , ,             |   | Yes 2 □No                                   |                                   |                                    |  |
| Division of Vital Records, | for Attenuater deat<br>Director;<br>in by the  | ertification.     | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At ho<br>building, etc. (Specify       | me, farm, st    | reet, factory, office                   |   | 28f. Location (St<br>City or Town | reet and Number or in, State)      | Rural Route Number,                                  |
|                            | talor<br>rs afte<br>al Dir<br>ed in  | Cer               |   |   |                 |   |   |                                   |                                    |  |
|                            | Hospital 4 hours a Funeral tely filled   | cal               |   | sicien: To the best of my kno<br>ner: On the basis of examina |                 |   |   |                                   |                                    |  |
|                            | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.   | ledical           | one)  | and manner stated.  |                 |   |   |                                   |                                    |  |
|                            | With<br>To I   | Σ                 | 29b. Signature and title of certifier   | MA  |                 | 29c. Licens                             | se number                                   | C. 2                              | 9d. Date signed (Mo.               | nth, Day, Year)                                      |
|                            | P  |                   |   |   |                 | DO                                      | 06516                                       | >7                                | 7/4/0                              | 76   |
|                            | 20   |                   | 30. Name and address of person who co   | ompleted cause of death (Item                                 | 23а) (Туре,     | Print) N \IA                            |   | a mi                              | . /-                               |  |
|                            |  |                   | Mapphew Mathell   | rew 18101   | MMV             | rop PMI                                 | 12 BLICE                                    | 4 Ulv                             | vey MD                             | 20835  |
| Sec. Of                    | St<br>Regist   | ate               | 31. Date filed (Month, Day, Year)   | 32 Registrar's Signa  | ture            | arte D                                  | 1   |                                   | l .                                |  |
| 3 1                        | negisi   | ादा               | I JUL (Fi) Zt   | TOU PROMOBERS A   | - 1             |   |   |                                   |                                    |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 22551 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month Year **Physician** MILDRED CECILE BAYLY JULY 2006 6:50PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** GENESIS LA PLATA CENTER LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2000 90 Yrs. Director 577-03-2798 NOV.17,1915 NEW ORLEANS Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show avant, the Medical Evandrer must be notified at 1 ☐ Yes ŽÍNo MARYLAND CHARLES HUGHESVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Itams 23a death v 6725 MAXWELL DRIVE Funeral 20637 14. Race - American Indian, Black, White, etc. U.S 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status of filed within 72 hours after It Hygiene.
other than "natural", or Ital 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLASSIFIED SUPERVISOR 8 WASHINGTON POST permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if itam 27 is marked othe any injury or other traumatic avant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ADAM HEBERT EVA MARTINEZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT SCHWIER-SON 6725 MAXWELL STIVE, MUGHESVILLE, MD 20637 ition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Xurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) WOODFIELD CEMETERY 7-11-06 GALESVILLE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee once. RAYMOND FUNERAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. lucha X Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DUANCIND disease or condition resulting in death) /Medical Que to (or as a consequence of). Examiner ABETE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deal 2 Fetal death 3 Ectopic pregnancy Dav Year 5 Other (specify) 1 Yes 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 100 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 건 1 🗌 Yes 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural 1 Tes 2 No 2 Accident after death Director: in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral D Descritiving Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continued at the time, date and place, and due to the cause(s) and manner as stated.

| Continued at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical one) and manner stated. 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) DP completed cause of death (Item 23a) (Ty Name and address of person who 11. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

2008

|                            |  |  | State of Maryland / E<br>State of Maryland / E<br>State of Maryland / E<br>State of Maryland / E<br>Pegistrar                         | Department of Health and Me<br>ME C857 07/15/06dhb<br>Certificate of Death   | ental Hygie                           | ene 2006 22552  |  |
|----------------------------|--|--|---|--|---------------------------------------|---|--|
|                            |  |  | Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month             | Day Year  |  |
|                            | Physici<br>/Medic  |  | Blanche Elizabeth Birchfie  | ld J   |                                       | 6, 2006 7:30p M   |  |
|                            | Examin   | a  | ta. Facility Name (If not institution, give street and number)  Corsica Hills Nursing Home  | 4b. City, Town, or Location of Death  Centreville  |                                       | 4c. County of Death Queen Annes   |  |
|                            | Funeral  |  | 5. Social Security Number 6. Sex 7. Age (In yrs. last birth   | hday) If Under 1 Year If Under 24 Hrs.   | 8. Date of Birth                      | 9. Birthplace (State or Foreign   |  |
|                            | Director   |  | 213–34–5273 <sup>1□ M 2</sup> ♥ 69  | rrs. Months Days Hours Min.  | Month, Day, Y<br>Feb. 9               |   |  |
|                            | pu. ≱  | -  | Usual Residence of Decedent   10a. State   10b. County   10c. City, Town  |  |                                       | 10d. Inside City Limits   |  |
|                            | faryla<br>sho<br>ed al   | ō  | MD Queen Annes  | Chester  |                                       | 1 ☐ Yes 2√ No   |  |
|                            | 28a-1  | Director   | 10e. Street and Number  | 10f. Zip Code  | 100                                   | . Citizen of What Country?  |  |
|                            | 3a or  | <u> </u>   | 502 Skipper Court   | 21619  |                                       | USA   |  |
|                            | death<br>ms 2  | Funeral  | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?  | 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R   | ify Yes or No-                        | 14. Race - American Indian,<br>Black, White, etc.                         |  |
| 9                          | 72 hours after death with the Maryland<br>natural', or items 23a or 28a-f show<br>Jical Examinat must be notified a  | /Fu  | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No  | 1 ☐ Yes 2 ☑ No Specify:  | ilcan, elc.)                          | Specify: White  |  |
| 21215-0036                 | ural',   | d by   | 3 XWidowed 4 □ Divorced Year or Dates:  |  |                                       |   |  |
| 15-                        | n 72   | lete   | (Specify only highest grade completed)  | Decedent's Usual Occupation<br>(Give kind of work done during most of workin<br>life. DO NOT use retired)  | g le                                  | b. Kind of Business/Industry  |  |
| 212                        | iene.  | Completed  | Elementary/Secondary (0-12) College (1-4or 5+)  | Clerical   |                                       | Roofing Company   |  |
|                            | e filec<br>at Hyg<br>othe<br>vent,   | Be C   | 17. Father's Name (First, Middle, Last)   | 18. Mother's Name  |                                       |   |  |
| ylar                       | 2 should be filed within 72 hours after dea<br>and Mental Hygiene.<br>Is marked other than "natural", or items<br>reumatic event, the Worlell Examinating  | 70 E   | Edward L. Couch   | Margaret   | M. Fost                               | er  |  |
| Maryland                   | 2 sho<br>and<br>Is my  |  |   | Mailing Address (Street and Number or Rural  |                                       |   |  |
|                            | l and<br>lealth<br>om 27<br>her 1  |  |   | 356 Wicomico Road, Ste   |                                       | Le, MD 21666  |  |
| Baltimore,                 | permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Menial Hygiene. Importent: If item 27 is marked other than "natur any injury or other treumatic event, Ite Madical Once. |  | 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State cemeter   | y, crematory or other place) June  | 23,                                   |   |  |
| Itin                       | artmer<br>artmer<br>ortent<br>injury   |  | '4 □Donation 5 □Other (Specify) Birch   |  |                                       | Lester, WV  |  |
| Ba                         | Depar<br>Impor<br>any ir   | 1  | Innese In cons  | 495 Gov. Ritchie H   | .A. Seve                              | rna Park Funeral Home<br>rna Park, MD 21146                               |  |
|                            |  | Ċ  | 23a. Parti. Enter the disease, or complications that caused the death. Do r shock, or hear failure. List only one cause on each line. |  | _= -                                  | •   |  |
|                            | Physician  |  | Immediate Cause (Final disease or condition  a. AS Much D.  | n Pneumonia  |                                       | Onset and Death   |  |
|                            | /Medical   |  | resulting in death)  Due to (or as a consequence of   | of):   |                                       | 2003  |  |
|                            | Examiner   |  | Requentially list conditions, b. Luwa Canc  | or ///   |                                       |   |  |
|                            | ed sit   | Examine  | Requentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                           | or):   | 5                                     | MINER   |  |
|                            | be executed<br>iician and<br>burial-transit  | xan  | that initiated events c.  resulting in death) Last Due to (or as a consequence of   | of):   | ED BY MEDICAL D                       |   |  |
| 8760,                      | ate be execut<br>hysician and<br>the burial-trar   | dical E  | <b>U</b> ₫  | or):  CERTIFICATION ASSOCIATION ASSOCIATIO |                                       |   |  |
| 9                          | tific<br>g p   | ledi   |   |  |                                       |   |  |
| Вох                        | death certifica<br>e attending pl<br>ed for use as t   | by Physician/Me  | IF FEMALE: 23b. Was decedent pregnancy 1 ☐ Live birth 2 ☐ Fetal death   | 3 Ectopic pregnancy  |                                       | 23d. Date of delivery   |  |
|                            | 0 0 0  | sicia  | in the past 12 moords?  1   | 5 Other (specify)  |                                       | Month Day Year  |  |
| P.0                        | hat the  | Phy  | Part II. Other significant conditions contributing to death but not resulting in  | the underlying cause given in Part I   | 23a. Did toba                         | cco use contribute to the cause of death?                                 |  |
| Division of Vital Records, | es<br>g  | d by   | Δ.  | The street, and st |                                       | 2 No 3 Probably 4 Donknown  |  |
| Ö                          | > 0 0  | Completed  | Rr his parture  |  | 24a. Was an                           | 24b. Were autopsy findings available                                      |  |
| Rec                        | e la<br>has<br>je 2  | duc  | N his pacute  |  | autopsy<br>performe                   | prior to completion of cause of death?                                    |  |
| tal                        | ician: Th<br>certificate<br>rector, pag  | a)   | 25. Was case referred to medical  | 26. Place of Death   |                                       | ZNo 1 ☐ Yes 2 DATo  |  |
| Ξ                          | Physician:<br>this certific<br>ral director,   | To B   | examiner?  1 X Yes Hospital: 1 Inpatient 2 ER/Ou  | Othor  |                                       | ce 6 Other (Specify)  |  |
| O L                        | ding Ph<br>h.<br>After th<br>funeral   | ü  | S Pending (Wonth, Pay Year)   | ime of 28c. Injury at 26   | 8d. Describe how                      | injury occurred   |  |
| Sio                        | Attending r death. ector; Atterby the fune   | catle  | CT Could not be   |  | Subject :                             |   |  |
| Σ                          | or Att   | Certification:   | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, fa building, etc. (Specify)  Nursing home      | rm, street, factory, office  | Bf. Location (Stre<br>City or Town, 1 | et and Number or Rural Route Number,<br>State)<br>Hills N.H., 2054 mstror |  |
|                            | pltel  | 2  | 29a. Certifier 1 ertifying Physician: To the best of my knowledge   | death occurred at the time, date and place, a  | lve Cen                               | treville MD   |  |
|                            | To the Hospitel or Attendi<br>within 24 hours after death.<br>To the Funerel Director; A<br>completely filled in by the fu   | edical   | (Check only 2 Medical Examiner: On the basis of examination an and manner stated.   | d/or investigation, in my opinion, death occurre   | d at the time, date                   | and place, and due to the cause(s)  |  |
|                            | To th<br>To th<br>comp   | Me   | 29b. Signature and title of certifier   | 29c. License number  | 290                                   | . Date signed (Month, Day, Year)  |  |
|                            |  |  | R. R. Dual Mo   | D0061688   | C                                     | 16/19/06  |  |
|                            | 7  | 1  |   | Type, Print)   | ( Ba + = 1 - +                        | 110 2 11 10   |  |
|                            | -  | -  | Dr. Rupal K. Dinai, 2108  | DIPONARO UNVE  | cruroc                                | MD 21619  |  |
|                            | Sta<br>Regist  |  | 31. Date filed (Month, Day, Year) 32. Registrar's Signature   | ! Couls  |                                       |   |  |
|                            | ricgist  | 30. Name and address of person who completed cause of death (item 23) (type, Print)  Dr. Rupal R. D. Charles 2108 Di Donaro Drive Churtur MD 216 19  ate rar JUL 13 2006 32. Registrar's Signature  JUL 13 2006 April 19 |   |  |                                       |   |  |

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** 1:45 26 Alonza Birckhead June Kevin 2006 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 23100 Nanticoke Road Quantico Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct.15 19 6. Sex 12 M 2□ F **Funeral** Months Days 215-62-2413 50 Yrs Director 1955 Maryland Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health end Mental Hygiene.
ant: If Item 27 is marked other than "natural; or items 23s or 28s-f show ury or other traumatic event, i're Madical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Wicomico Quantico 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 23100 Nanticoke Road Funeral 21856 U.S.A 12. Wes Decedent Ever in U,S. Armed Forces? 1 → Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 KNo Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1974-77 Black 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Laborer None 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Unknown Geraldine B.Birckhead 19a. informant's Name/Relationship (Type, Print) Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Chestnut St. Hebron, Md. 21830 <u>Geraldine B.Robinson</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H important: If its any injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Mem Garden 4 ☐ Donation 5 ☐ Other (Specify) Hebron, Md. 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility
Stewart Funeral Home West Rd. Salisbury, Md. 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner the Hospital or Attending Physician: The law requiras that the death certificate be axecuted the bunal-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. ettending physician Physiclan/Medical Due to (or as e consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending ple completaly filled in by the funeral director, page 2 should be detached for use as to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2□ No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1□ Yes 2☑ No edicai Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manney of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of deeth (Item 23a) (Type, Print) 30. Name and address of person 29466 DR DAVID 31. Dete filed (Month, Day, Year) 32. Begistrar's Signature State

Registrar

JUN 3 0

#### 06

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| 6-04900  |                   | Please Type or Print in Black Indelible Ink  |                          |                               |   |
|--|-------------------|--|--------------------------|-------------------------------|---|
| yron Douglas E   |                   |  | lygiene                  | 0.00                          |   |
|  |                   | 1- For State Certificate of Death  | Re                       | g No.                         | 6 2255                                    |
| Physicia   | 31116             | 1. Decedent's Name (First, Middle,Last)  | 2 Date of Death<br>Month | h<br>Day Year                 | 3. Time of Death                          |
| Medical Exami  | ner               | Byron Douglas Bratcher, Jr.  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deal   | July 10, 20              | 006                           | 1012 hrs                                  |
|  |                   |  | th                       | 4c. County of Ligath Harford  | 1   |
|  |                   | 919 Topview Drive Edgewood   |                          |                               |   |
| Funeral  |                   | 5. Social Security Number 6. Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hi Months Days Hours Mi  | _                        | Foreig                        | thplace (State or                         |
| Director   |                   | 216-78-2297   1X M 2 F 48 Yrs  | 06/17/                   | 1958 <sup>Co</sup>            | untry)Virginia                            |
| 8  |                   | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |                          |                               | 10d Inside City Limits                    |
| w an   |                   |  |                          |                               | 1 X Yes 2 No                              |
| laryland<br>28a-f show any<br>at once.   | ē                 | MD Harford Edgewood  | 1                        |                               |   |
| Mary<br>r 28a  | e<br>S            | 10e. Street and Number 10f. Zip Code   | 10                       | g Citizen of What Cou         | ntry?                                     |
| h the  | Funeral Director  | 919 Topview Drive 21040  |                          | USA                           |   |
| th wit   | era               | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (\$\frac{1}{2}\$ Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puert |                          | 14. Race - Amer<br>White, etc | ican Indian, Black,                       |
| or it  | ᆵ                 | 1 Yes 2 X No   |                          | o ii tilla                    | : + a                                     |
| s afte<br>rral",   | ā                 | 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify.  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of     | work dono                | Specify: Who                  |   |
| hour<br>Fxar   | ted               | Elementary/Secondary (0-12) College (1-4 or 5+)  |                          | TOD KING OF BUSINESS/         | il idusti y                               |
| 36<br>tin 72<br>than<br>dical  | ompleted          |  |                          |                               |   |
| 5-0036<br>led within 72<br>Tygiene<br>other than '   | ě                 |  | ne (First, Middle, M     | laiden Surname)               |   |
| 21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica  | Se C              | Runan D Rhatchen Sh Nancu  | Mario D                  | o Mu P P                      |   |
| AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once  | 2                 | Byron D. Bratcher, Sr. Nancy  19a Informant's Name/Relationship (Type, Print)  19b. Mailing Adoress (Street and Number or  | Rural Route Num          | ber, City or Town, State      | Zip Code)                                 |
| ore, MD 2121 s. I and 2 should be if of Health and Mental If item 27 is marked ner tranmatic event,  |                   | Nancy M. Bratcher- Mother 801 Lafayette St., Ho  | avre de (                | Grace. MD 2                   | 1078                                      |
| G, C, L and I and Healt item   | Ì                 |  | Date                     | 20c. Location - City or       | Town, State                               |
| nore<br>ages l<br>nt of H<br>nt: If i  |                   | A Burlar 2 Cremation 3 Kemoval non State   | /15/06                   | Hauro do O                    | Stace MD                                  |
| Baltimore, permit Pages I ar Department of Her Important: If ite   | ŀ                 | 4 Donation 5 Other Specify: Angel Hill Cemetery 07 21. Signature of Funeral Service Licensee RP, Nerge, and April 1987.  | and Han                  | no DA                         | mace, mo                                  |
| Injury Derry |                   | 21. Signature of Funeral Service Licensee  Aukins M. Smith-Bioman 123 S. Washington,   | Havre o                  | le Grace MD                   | 21078                                     |
| Physician  | Ť                 | 239 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.                  | or respiratory arre      | st, shock, or heart           | Approximate Interval<br>Between Onset and |
| /Medical   |                   | Immediate Cause (Final disease a Methadone intoxication and cocaine use  |                          |                               | Death                                     |
| Examiner   |                   | or condition resulting in death)  Due to (or as a consequence of)  | ****                     | · ·                           |   |
| · · · · · · · · · · · · · · · · · · ·  | _                 | Sequentially list conditions,  |                          |                               |   |
|  | Examiner          | if any, leading to immediate cause. Enter Underlying Cause  Due to (or as a consequence of):   |                          |                               |   |
|  | Kam               | (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  |                          |                               |   |
| executed<br>ian and<br>ial - transit   |                   | d  |                          |                               |   |
| re exe   | Physician/Medical | ** unpended item#1,23a,27,28a-f,perME,8858,8/3/06  | 5 TT                     |                               |   |
| 68760,<br>rertificate be<br>rding physic   | ₩.                | IF FEMALE: 23c. If yes, outcome of pregnancy   |                          | 23d Date of delivery          | ,   |
| 68°  | ian               | past 12 months?  | nancy                    | Month E                       | Day Year                                  |
| Box death of the attented for us   | /sic              | 1 Yes 2 No 9 Unknown 9 Unknown   |                          |                               |   |
| Che d  | F.                | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | 23e Did tol              | bacco use contribute to       | the cause of death?                       |
| Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physici page 2 should be detached for use as the buri  | ð                 |  | 1 Yes                    | 2 No 3 Prob                   | eably 4 🗸 Unknown                         |
| ords,  ** require  s been si should b  | Completed         |  | 24a Wasa                 |                               | topsy findings available                  |
| COF<br>law I<br>has b  | 힏                 |  | autops<br>perforr        | med? death?                   | ompletion of cause of                     |
| Re<br>ficate<br>page   | 8                 | CO Plant of Double (Ob et  | 1 ✓ Yes 2                | No 1 ✓ Ye                     | s 2 No                                    |
| Vital Rechysician: The this certificate  | Be                | 25 Was case referred to medical examiner?  [Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Other Nurse   |                          | Residence 6 🗸 Other           |   |
| of Vi<br>Physi<br>er this<br>eral dir  | 유                 | 1 V Yes 2 No   |                          | ow injury occurred            | . Scerie                                  |
| n of ding Ph   | <u></u>           | 1 Natural 5 Deadline T + T (April 1997)  |                          | ,,                            |   |
| Sior<br>Attenc<br>r death<br>ector:<br>by the  | cat               | 2 Accident Investigation 2Re Place of Injury. At home farm street factory office building etc.   | 2Bf Location (S          | treet and Number or Ru        | ral Route Number City                     |
| Division of Vital Records, piral or Attending Physician: The law requirours after death.  eral Director: After this certificate has been stilled in by the funeral director, page 2 should the   | Certification:    | Suicide Suicide Specify formed in regardence   | or Town, St              | ate) 919 Topvie               | w Drive                                   |
| lospit<br>I hour<br>uner;  |                   | 29a Certifier 4 Continue Physician: To the best of my knowledge, death accurred at the time date and place an  | I Edgewood.              |                               | ed  |
| Division of Vital F To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director.  | ica               | one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred  |                          |                               |   |
| To To cont   | Medical           | and manner stated  29b. Signature and title of certifier  29c. License number  |                          | 29d Date signed (Mor          | nth, Day, Year)                           |
|  | -                 | 0.C.M.E.   |                          | 7/11/m                        |   |
|  |                   | 30. Name and address of person who completed cause of death (Item 23a)   |                          | 1/11/00                       |   |
| 9  |                   | Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, ME   | 21201                    | t t                           |   |
| 9  | tate              | 31 Date filed (Month, Day Year) 32 Registrar's Signature   |                          |                               |   |
| Regis  |                   | JUL 1 5 2006 Meeter St. Species  |                          |                               |   |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 2, **Physician** Richard Vincent Carey 2006 8:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10314 Old Ocean City Blvd. Worcester Berlin 8. Date of Birth (Month, Day, Year) Jan. 9, 1932 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country) Months Days Hours 1**X**□M 2□F 214-28-3437 Yrs. 74 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "netural", or items 23s or 28s-f show the Medical Examiner must be nutified at 1 Yes 2 No Worcester Berlin Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10314 Old Ocean City Blvd. 21811 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 12/Yes 2 1 No 1 953 - 1 955

1/ Yes, Give Year or Dates: 1 955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter Grocery Store 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental h Pages 1 and 2 should be Russell William Carey Ida Pauline Baker Kelley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 Carol Johnson 8811 Old Ocean City Rd., Berlin, Md. 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition ō = 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If eny injury or 2005. 7-3-2006 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 21. Signature of Furnal Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 23a. Part 1. Enter the disease, or complication it at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one callse by each line. Approximate Interval Between Onset and Death THEROSCIENIAC CARDIOVASCINAR DISENSE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner REMAR DISENSE STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the deeth certificate be executed anding physicien and use as the buriat-transit TYPERTENSUNT Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown sete has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 No 1 ☐ Yes After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending s after dea. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide within 24 hours a 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DO CCEMPLATE BLVD, BERLIN, NO ZIEI) 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State 2096 JUL 05 Registrar

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Physician Ju1y 4,2006 6:40 A M CROSCO Curtiss /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Neme (If not institution, give street and number) Examiner Garrett County Memorial Hospital 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F 215-12-2123 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28e-f show the Medical Examinar must be recitied at 1 ☐ Yes 2 🕅 No Director Oakland MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3667 Hutton Road 21550 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: ģ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Government Collection Site Attendant 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othen any injury or other traumatic event 2008. Tony Crosco Estella Knox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice J. Crosco/ Wife 3667 Hutton Road, Oakland, Maryland 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Pleasant Valley Cem. 7/8/06 Oakland, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility 32 S. Second St. Stewart Funeral Home Oakland, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) Ischemic Cardiomyopathy Years **Physician** /Medical Due to (or as a consequence of): Examiner Arteriosclerotic Heart Disease Years Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetaf death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No 1 Yes 2<del>□</del>No 1 Yes After this certific funeral director, Be 25. Was case referred to medicaf examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 🗌 No Inpatient 2 ER/Outpatient 3 DOA 2 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Tes 2 No i Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Mil D () 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 311 N. Fourth St., Oakland, Maryland Dr. Thomas Johnson, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 10 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death 2. Date of Death 3 Time of Death Decedent's Name (First, Middle, Last) June 24, 2006 **Physician** 1930 hrs₩ Colvin Martina Barbara /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Prince Georges Hospital Center Cheverly 8. Date of Birth (Month, Day, January If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 26,1931 Washington,DC 1 □ M 2 K F Months Days Hours Yrs. 579-38-0955 75 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a. State 28a-f show doer coust be notified at 1X Yes 2 □ No District of Columbia Washington Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Items 23a or 20001 United States 1117 McCollough Court; N. W.; Apt. 103 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Marned ŏ 1 ☐ Yes 2X No Specify: **Black** Specify: the Madical Exp. δ 3 Widowed 4 Divorced natursi Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Calvary Christian Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Day Care Provider Academy permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: if Item 27 is marked other th any Injury or other traumatic event, tha once. 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gaither Henry Jeff Ke11y Eva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Gary Wright (Son) 5600 North Capitol Street, N.W.; Washington, D.C. 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) June 30,2006 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ Removal from State Lincoln Memorial Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Nuneral Service L R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 months Multiple Myeloma Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical as attending for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2**X** No Division of Vital Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending Pl within 24 hours after death. To the Funeral Director; After the completely filled in by the funera 27. Manner of Death Certification: After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 27, 2006

Maryland 21215-0036

Baltimore,

Box 68760

o

31. Date filed (Month, Day, Year) State 0 3 2006 Registrar

May

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan H. Houseman, M.D.; 2100 Pennsylvania Avenue, N.W.;5th Floor; Washington, D.C.

Housemen, Mr

Dc 9603

20037

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2006 **Physician** June 27 Clark 2115 M Lafayette /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner ROCKVIIIE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Nav. Pear)

July 30,1919 Kentucky Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1□ M 2XF 306-22-9979 86 Yrs. Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location , or Items 23a or 28a-f ehov the Medical Examiner must be notified at Md. Montgomery Rockville ¥Yes 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9701- Veirs Drive 20850 USA 12. Was Decedent Ever in U.S. Agned Forces? 14E]Yes 2□No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: 3X Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within 7 al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Beautician Beauty 12 18. Mother's Name (First, Middle, Maiden Sumame)
Rozell Chisolm 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny jury or other traumatic event 9058. Be Frank Warr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janise Clark-Daughter 110- Lavenport Circle, Frederick, Md. 21702 Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Gate of Heaven Cem. 7/1/2006 Silver Spring, Md. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hysong Co., Inc.
6510-16th St., NW, Wash., DC W. W 23a. Part1. Enter the disease, or shock, or heart failure. List of Approximate Interval Between Onset and Death emplications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Day Hyperkalemia /Medical Due to (or as a consequence of) Week Examiner Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Days Attending Physician: The law requires that the death certificate be executed burial-transit Sepsis Due to (or as a consequence of): Days Box 68760 Pneumonia Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 3 Ectopic pregnancy signed by the atte Month 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulfing in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes **2** No 1 Yes Division of Vital After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 28b. Time of 1 Natural 5 Pending after death.

I Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or To the Hospital within 24 hours a To the Funeral I 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of entitier 29c. License number 29d. Date signed (Month, Day, Year) 64407 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901-Medical Center Dr., Rockville, Md. 20850 ReBecca Barker 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUL 0 3 2006

DHMH 17 Rev 1/2001

Registrar

|                |  | 1                   | For<br>Stete<br>Registrar   | State of Marylan   |                                  | rtment of H<br>tificate of L                               |  |   | iene<br>g. No. 20                    | 06 2  | 22560                                  |
|----------------|--|---------------------|---|--|----------------------------------|--|--|---|--------------------------------------|---|--|
| 15.            |  |                     | . Decedent's Name (First, Middle, Last)   |  |                                  |  |  | 2. Date of Deat<br>Month                  |                                      | ear 3. T                                    | ime of Death                           |
|                | Physicia<br>/Medic   | _                   | Barbara A. Coakley  |  |                                  |  |  | July                                      | 4 200                                | 6:  | 40 P M                                 |
|                | Examin   | _                   | a. Fecility Name (If not institution, give str  | eet and number)  |                                  |  | Location of Death                                    |   | 4c. County of                        |   |  |
| 18/44          |  |                     | 40 Bryans Mill Way  |  | t t : at - t t                   | Catons If Under 1 Year                                     | V111e If Under 24 Hrs.                               | 8. Date of Birth                          |                                      | timore                                      | State or Foreign                       |
|                | Funeral  | 1                   | 5. Social Security Number 6. Sex 1 1 N  | 7. Age (In yrs. )  | Yrs.                             | Months Days  | Hours Min.   | July 28                                   | Year)                                | Maryla                                      | _                                      |
| 100            | Director   | -                   | Jsual Residence of Decedent   | 04   |                                  |  |  | July 20                                   | , 1741                               | ran y na                                    | I ICA                                  |
|                | yland<br>yland   |                     | 10a. State 10b. County  | 10c. Cit   | y, Town or Lo                    | cation   |  |   |                                      |   | side City Limits                       |
|                | Hist   | to                  | MD Baltimore  | Ca   | tonsvi:                          | l·le   |  |   |                                      | 11  | Yes 212 No                             |
|                | or 28  | lire                | 10e. Street and Number  |  |                                  | 10f. Zip Code  |  | 1   | 0g. Citizen of Wh                    | at Country?                                 |  |
|                | 23a  | la l                | 40 Bryans Mill Way  |  |                                  | 21228  |  | 7 17                                      | United                               | States  American Ind                        | ion                                    |
| 36             | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked othsr than "naturel", or Items 23a or 28e-f show or other treumatic avent, the Modical Exempler must be rutilised at | by Funeral Director | 11. Marital Status  12 Never Married 2 Married  3 □ Widowed 4 □ Divorced                                      | . Was Decedent Ever in U.<br>Armed Forces?<br>1 ☐ Yes Æ No<br>If Yes, Give<br>Year or Dates: |                                  | Vas Decedent of Hi<br>f Yes, specify Cuba<br>I □ Yes 2€ No | spanic Origin? (Sp<br>n, Mexican, Puerto<br>Specify: | Rican, etc.)                              |                                      | White, etc.                                 |  |
| 21215-0036     | hour<br>turel  | ed b                | 15. Decedent's Educa  |  | 16a. Deced                       | lent's Usual Occupa  | ation  |   | 16b. Kind of Bus                     |   | <u> </u>                               |
| 5              | n "ne  | Completed           | (Specify only highest grade Elementary/Secondary (0-12)   | completed) College (1-4or 5+)  | (Give<br>life. L                 | kind of work done of<br>OO NOT use retired                 | during most of work<br>)                             | ting                                      | Our Lady                             | of Per                                      | rpetual                                |
| 212            | filed with<br>Hygiene.<br>other than   | mo;                 | Elementary/Secondary (5 12)   | 5+   | Schoo                            | ol Princi  | <del></del>  |   | Help S                               |   |  |
| g              | al Hy<br>I othe  | Be                  | 17. Father's Name (First, Middle, Last)   |  |                                  |  | 18. Mother's Nam                                     | . ,                                       |                                      | )   |  |
| yla            | should be<br>nd Mental<br>marked c   | 2                   | Oliver E. Coakley   |  |                                  | _  | Marie E  |   |                                      | 7 0 4                                       |  |
| Maryland       | 2 sho<br>and<br>is ma<br>reum  | 7. II               | 19a. Informant's Name/Relationship (Type  |  |                                  | g Address (Street a  |  |   |                                      |   | )                                      |
|                | 1 and 2<br>Health<br>tem 27 i  | 7-                  | Nora C. Reiter/Sis  | 20b. F   | lace of Dispo                    | Montrose sition (Name of                                   |  |   | Le, MD 2<br>20c. Location - C        |   | late                                   |
| ğ              | ages<br>nt of h<br>: If ite  |                     | 1 Burial 2 □ Cremation 3 □ Re   | moval from State   | emetery, cren                    | natory or other plac                                       |  | 2006                                      | n = 1 + 4 =                          | M   |  |
| Baltimore,     | it. Partiment  | 1                   | <ul> <li>4 □Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licensee</li> </ul>        |  |                                  | nedral Ce<br>. Name and Addres                             |  |   | Baltimor<br>itzko!s                  |   | FH Inc                                 |
| Ba             | permit. Pages 1 an<br>Department of Heali<br>Importent: If item 2<br>eny injury or other<br>ance.  |                     | Sem Collis  | Wille 1101   |                                  | 112 Old C  |  |   |                                      |   |  |
| Ž.             | Physician  |                     | 23a. Pert1. Enter the disease, or complic<br>shock, or heart failure. List only one<br>Immediate Cause (Final | ations that caused the deat<br>cause of each line.   | h. Do not ent                    |  | g, such as cardiac                                   | or respiratory arm                        |                                      | Approinten<br>Onse                          | oximate<br>val Between<br>at and Death |
| W.,            | /Medical<br>Examiner   |                     | disease or condition resulting in death)  | Due to (or as a conseq   |                                  | (100)100   | / IN (03) =  | , , , ,                                   | 17.017                               |   | 1411-                                  |
|                | pe tis   | lner                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as a conseq   | uençe of):                       |  |  |   |                                      |   |  |
| .00            | icate be executed<br>physician and<br>s the burial-transit   | I Examiner          | that initiated events c. resulting in death) Last   | Due to (or as a conseq   | juence of);                      |  |  |   |                                      |   |  |
| 8760,          | physic the k   | ledical             | d.  |  |                                  |  |  |   |                                      |   |  |
| O. Box 6       | death certif<br>le attending<br>ad for use a   | Physician/Me        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☎No 9 ☐ Unknown                        | c. If yes, outcome of pregna<br>1 Live birth 2 Feta<br>4 Pregnant at time of c<br>9 Unknown  | al death 3                       | Ectopic pregnancy<br>Other <i>(specify)</i>                | ,  |   | 23d. Date<br>Mont                    | of delivery<br>h Day                        | Year                                   |
| ds, P.         | es this<br>gned<br>be de   | þ                   | Part II. Other significent conditions cont  | ributing to death but not res  | sulting in the u                 | nderlying cause giv  | en in Part I.  | 23e. Did to                               | bacco use contrit<br>es 2 No 3       |   | se of death?                           |
| Vital Records, | The law requir<br>ate has been si<br>page 2 should   | Completed           |   |  |                                  |  |  | 24a. Was a autop: perform                 | sy pr<br>med? de                     | ere autopsy fir<br>ior to completi<br>eath? |  |
| tal            |  | a                   | 25. Was case referred to medical  |  |                                  |  | 26. Place of Dea                                     | th (Check only or                         |                                      |   |  |
| Σ              | ysic<br>Is ce<br>direc   | To B                | examiner?<br>1 ☐ Yes 2 🔀 No   | spital: 1   Inpatient 2  | ER/Outpatier                     | nt 3 DOA Oth   | er: 4 🗆 Nursing H                                    | ome 5X Resid                              | ence 6 Other                         | (Specify)                                   |  |
| ion of         | ding<br>7.<br>After<br>fune  |                     | 27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation                                       | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time o<br>Injury            | Wor  | yat<br>k?<br>Yes 2 □ No                              | 28d. Describe h                           | ow injury occurre                    | d   |  |
| Division       | of or Attendi<br>after death.<br>Director: A<br>d in by the fu   | Certification:      | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At h<br>building, etc. (Speci   | ome, farm, sti<br>fy)            | reet, factory, office                                      |  | 28f. Location (S<br>City or Tow           | treet and Numbe<br>n, State)         | r or Rural Rou                              | te Number,                             |
|                | To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by   | Medical C           | 29a Certifier 1X Certifying Phys (Check only one) 2 Medical Examin  | ciert: To the best of my know.  On the basis of examination and manner stated.               | owledge, deat<br>ation and/or in | h occurred at the tir<br>vestigation, in my o              | ne, date and place<br>pinion, death occu             | , and due to the c<br>rred at the time, c | ause(s) and man<br>late and place, a | ner as stated.<br>nd due to the c           | cause(s)                               |
|                | To the within 2 To the complete  | Me                  | 390 Signature and little of pertifier   | asi  | last                             | 29c. Licens  | e number   | 2   | 29d. Date signed  July 5             |   | Year)                                  |
| 9              | The  |                     | 30. Name and address of person who cor  | npleted cause of wath stee   | 7 23a) (Type                     | Print) ATON A  | VE. B  | ALTIMOR                                   | E M                                  | 5 21:                                       | 229                                    |
|                | St<br>Regist   | ate<br>rar          | 31. Date filed (Month, Day, Year)   | 32. 9 gistrar's Sign   | ature                            | berke  |  |   |                                      |   |  |
|                | 4.   | Vi.                 | JUL 0 CO  |  |                                  |  |  |   |                                      |   |  |

|    | ret <sub>e</sub>  | se T             | 1 - State<br>Registrar #29d, per<br>1. Decedent's Name (First, Middle, La.  |   |   |   | 2. Date of<br>Month                                 |                                      | U U D<br>Year                | 3. Fime-of Death  |
|----|---|------------------|---|---|---|---|---|--------------------------------------|------------------------------|---|
|    | Physicia<br>/Medic  |                  | Mabel Jones Cohe  | en  |   | July 2, 2006 0  |   |                                      |                              |   |
| 5  | Examin  |                  | 4a. Facility Name (If not institution, give   | e street and number)  |   | 4b. City, Town, or Locatio  |   | 4c. County of Death                  |                              |   |
|    |   |                  | 8810 Walther Blvd   |   |   | Parkvi  |   | В                                    |                              | re Co.  |
| 46 | Funeral<br>Director   |                  | 5. Social Security Number 6. S 220-52-9170 1  | ex 7. Age (/n   | yrs. last birthday)<br>Yrs.               | If Under 1 Year If Und<br>Months Days Hours   | er 24 Hrs. 8. Date of (Month, 11/9)                 | Birth Year)                          | 9. Birthi                    | place (State or Foreign<br>htry)<br>MD                  |
|    | D .   |                  | Usual Residence of Decedent   | 140   | Oib. Tour sale                            |   |   |                                      |                              |   |
|    | aryla<br>ehov   | 7                | 10a. State 10b. County  |   | City, Town or Lo                          |   |   |                                      |                              | 10d. Inside City Limits<br>11 Yes 2 □ No                |
|    | within 72 hours after death with the Maryland<br>ene.<br>Than "naturel", or Itema 23a or 28a-f ehow<br>fra Modical Examinar must be notified at | Funeral Director | MD Baltimo  | re  | Baltimo                                   |   |   | 10- Cities-                          | -4 14/h - 1 O - 1            |   |
|    | with 1  | 급                | 8810 Walter Blvd  | l   |   | 10f. Zip Code 21234   |   | 10g. Citizen                         | or what Cou                  | ntry?   |
|    | eath  | era              | 11. Marital Status  | 12. Was Decedent Ever   | in U.S. 13. V                             |   | Origin? (Specify Yes or                             |                                      | Race - Ameri                 | can Indian.   |
|    | fier of Figure 1  | Fun              | 1 Never Married 2 Married   | Armed Forces?<br>1 ☐ Yes 2 🕅 No   |   | Was Decedent of Hispanic (<br>f Yes, specify Cuban, Mexic                                   |   | 8                                    | Black, White,                |   |
|    | ol', o  | by               | 3 ☑ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:  |   | 1 ☐ Yes 2 ☑ No Speci  | fy:   | Spe                                  | city: Wh                     | nite  |
|    | 2 ho  | Completed        | 15. Decedent's Ed   | ducation  | 16a. Deced                                | lent's Usual Occupation   | act of warking                                      | 16b. Kind of                         | Business/In                  | dustry  |
|    | thin 7  | pje              | (Specify only highest gra<br>Elementary/Secondary (0-12)  | College (1-4or 5+)  |   | kind of work done during m<br>DO NOT use retired)   | ost of working                                      |                                      |                              |   |
|    | TI TO S   | Con              |   | 4   | Mana                                      | <u> </u>  |   |                                      | try Fa                       | rm  |
|    | m - 0 =   | Be               | 17. Father's Name (First, Middle, Last)   | 1   |   |   | ther's Name (First, Mid                             |                                      | ame)                         |   |
|    |   | ၉                | Albert Jones  |   |   |   | thryn Riles   |                                      |                              |   |
|    | and<br>and<br>le m  |                  | 19a. Informant's Name/Relationship (  | Type, Print)  |   | g Address (Street and Num   |   |                                      |                              |   |
|    | s 1 and 2<br>if Health<br>Item 27<br>other tra  |                  | Rebecca C. Neal   | 100   |   | Parkview Bl   |   |                                      |                              |   |
|    | o to to   |                  | 20a. Method of Disposition  1XXBurial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif.  |   |   | sition (Name of<br>natory or other place)<br>Churchyard                                     | Date 7/7/2006                                       | Snow                                 | n - City or 10<br>HIII,      |   |
|    | permit. Pag<br>Department<br>Important: I<br>eny injury o   |                  | 21. Signature of Funeral Service Licer  | 1599  |   | . Name and Address of Fac   |   |                                      |                              | ome   |
|    | 88 = 88   |                  | Seell   | mul   |   | 108 WIlliam :   | St., Berlin   | , MD 21                              | 811                          |   |
|    | Physician<br>/Medical<br>Examiner   |                  | 232 art. Enter the disease of com-<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | a. Due to (or as a co   | estive                                    | er the mode of dying, such  | Failur  | Q                                    |                              | Approximate<br>Interval Between<br>Onset and Death      |
|    | sit 9d  | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                                       | b. — Due to (or as a col  | isoquelica di).                           | -   |   |                                      | = 01                         |   |
|    | te be executed<br>ysician and<br>ie burial-transit  | I Examiner       | that initiated events<br>resulting in death) Last   | Due to (or as a con   | nsequence of):                            |   |   |                                      |                              |   |
|    | # × 9   | edical           |   | _ d.  |   |   |   | 4                                    |                              |   |
|    | The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as the                    | Physician/Med    | IF FEMALE: 23b. Was decedent pregpent in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome of pr<br>1 ☐ Live birth 2 ☐<br>4 ☐ Pregnant at time<br>9 ☐ Unknown | Fetal death 3                             | Ectopic pregnancy Other (specify)   |   |                                      | Date of delive<br>Month      | ery<br>Day Year   |
|    | w requires that<br>been signed by<br>should be deta   | þ                | Part II. Other significant conditions of  | ontributing to death but no   |   | 23e. Did tobacco use contribute to the cause of death?  1  Yes 2  ONo 3  Probably 4 Unknown |   |                                      |                              |   |
|    | sician: The law re<br>certificate has be<br>irector, page 2 sho   | Completed        |   |   |   |   | 24a. W<br>au<br>pe<br>1 🗆 Ye                        | itopsy<br>informed?                  |                              | psy findings available<br>mpletion of cause of<br>2∐ No |
|    | ician<br>Sertifi<br>ector   | Be               | 25. Was case referred to medical examiner?  | Happitali   |   | 0+  | ce of Death Check on                                | Ne)                                  |                              |   |
|    | his his   | 2                | 1 Yes 2 No  |   | 2 ER/Outpatien                            |   | Nursing Home , 5                                    |                                      |                              | y)  |
|    | Attending F<br>death.<br>ctor: After<br>y the funer   | ertification:    | 27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  | 28a. Date of Injury<br>(Month, Day Yea  | 28b. Time of<br>Injury                    | 28c. Injury at Work?  M 1 □ Yes 2   |   | e how injury occ                     | urred                        |   |
|    | Hospital or Attending<br>4 hours after death.<br>Funeral Director: After<br>tely filled in by the fune.   | ertific          | 3 Suicide 6 Could not b 4 Homicide determined   | 28e. Place of Injury -<br>building, etc. (S   | At home, farm, street, oecify)            | eet, factory, office  | 28f. Locatio<br>City or                             | n (Street and Nu<br>Town, State)     | mber or Rura                 | d Route Number,   |
|    | ne Hospital or /<br>n 24 hours affer<br>ne Funeral Dire   | edical C         | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medical Exar   | ysician: To the best of my<br>niner: On the basis of exa<br>and manner stated.          | / knowledge, death<br>mination and/or inv | occurred at the time, date<br>restigation, in my opinion, d                                 | and place, and due to t<br>eath occurred at the tin | he cause(s) and<br>ne, date and plac | manner as s<br>e, and due to | tated. o the cause(s)                                   |
|    | To the within 2 To the Complet  | Me               | 29b. Signature and title of certiller   | MD  |   | 29c. License numbe  | 8.5   | 29d. Date sig                        | ned 74/3/                    | 06 Year)<br>37 / 3/06                                   |
|    | 1   |                  | 3) Name and address of person who   | completed cause of death  | (Itam 23h) /Tunn                          | Printl  | 1   |                                      | . [ ]                        | (00   |
|    |   | 1 3              | 1 talange   | Saw !   | hullen                                    | < BINA V  | arku. UE  | ( M ()                               | . 71                         | ムジム   |
| 27 | 115   |                  |   | 00000   | - /- v                                    | 1000  | 00001   | -1 1 1                               | 0                            | 0-5   |

Registrar

JUL 0 6 2006 See & July

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:26P<sup>M</sup> June 26, 2006 /Medical Fannie Cooley 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Clinton
If Under 1 Year If Under 24 Hrs. Bradfrod Oaks Nursing Home 8. Date of Birth (Month, Day, Year) April 9, 1919 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours 1□M 2QF Decula, GA. 87 171-20-4232 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mental Hygiene. importent: if item 27 is marked other then "natural", or items 23a or 28s-1 ehow withing or other treumatic event, the Madical Examinar must be notified at once. 1 Yes 2 No MD Fort Washington Director Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20744 4005 Payne Drive United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify à 3X Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Presser Laundry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claude Strickland Katie Marie Peet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Catherine Johns - Niece 4005 Payne Drive, Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairview Cemetery 7/05/06 Willow Grove, PA. 21. Signature of Juneral Service Lice 390 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street NW Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or pear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Breast Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: USe i 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☐No Month Day Year 4☐ Pregnant at time of death P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ cete hes been sig., page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2√ No Hospital or Attending Physicien: Be ( 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₹ No After this 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1X Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident the within 24 hours efter deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 🚰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D35206 6/27/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William T. Tanner MD 11701 Livington Road, Fort Washington, Maryland 20744 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature JUL 0 5 2006

DHMH 17 Rev 1/2001

Registrar

|                |   |                     | 1 - For Amend Item<br>Registrar   | State of per ME                                      | Marylan<br>,G857,                            | d//lg/<br>07/1g/                        | artment of<br><b>06dhb</b><br>rtificate of | Health<br>Death              | and M                      | lental Hy                      | giene2 ()                         | 06              | 22563                                       |
|----------------|---|---------------------|---|--|--|---|--|------------------------------|----------------------------|--------------------------------|-----------------------------------|-----------------|---|
|                | Physici   | -                   | 1. Decedent's Name (First, Midd   | dle, Last)   |  |   |  |                              |                            | 2. Date of De<br>Month         |                                   | Year            | 3. Time of Death                            |
|                | /Medic  |                     | Carl  | Wayne  | Cc   | le                                      |  |                              |                            | May 2                          | 0, 2006                           |                 | 4.00PM M                                    |
|                | Examin  | er                  | 4a. Facility Name (If not institution   | on, give street and num                              | ber)   |   | 4b. City, Town,                            | or Location                  | of Death                   |                                | 4c. County of                     | of Death        |   |
| *              |   | \$ 10               | Frederick   |  |  |   | Frede                                      |                              | 0411                       |                                | Frede                             |                 |   |
|                | Funeral   |                     | 5. Social Security Number 214-80-9962   | 6. Sex 7<br>1 1 1 2 1 F                              | 45. Age (In yrs.                             | last birthday)<br>Yrs.                  | If Under 1 Year<br>Months Days             |                              | Min.                       | 8. Date of Bin<br>Selfonth, Da | 16, 1960                          | 9. Birthpla     | ce (State or Foreign<br>aryland             |
|                | Director  |                     | Usual Residence of Decedent   | 1  |  | 113.                                    |  |                              |                            | bept.                          | 1500                              | 1 10            | ar y rand                                   |
|                | land<br>ow  |                     | 10a. State 10b. County  | у  | 10c. Cit                                     | y, Town or Lo                           | ocation                                    |                              |                            |                                |                                   | 100             | d. Inside City Limits                       |
|                | Mary<br>Heh   | tor                 | Maryland F  | Frederick  |  |   |  | Thur                         | nont                       |                                |                                   |                 | 1 Yes 2 No                                  |
|                | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Ifem 27 is marked other than "natural; or iteme 23s or 28s-1 show other traumatic event, its Medical Exeminar must be notified at | by Funeral Director | 10e. Street and Number 10832 Powell   | L Road   |  |   | 10f. Zip Code                              | <b>1</b> 788                 |                            |                                | 10g. Citizen of W                 | hat Country     |   |
|                | death   | nerg                | 11. Maritat Status  | 12. Was Deced  | ent Ever in U.                               | .S. 13.                                 | Was Decedent of<br>If Yes, specify Cul     | Hispanic Or                  | rigin? (Spe                | cify Yes or No                 | - 14. Race                        | - American      |   |
| 9              | after<br>or its   | Ē                   | Never Married 2☐ Ma   | rried 1 TYes 2                                       | X XNo  |   |  |                              |                            | Hican, etc.)                   |                                   | , White, etc    |   |
| 21215-0036     | ral',   | d b                 | 3 Widowed 4 Divorce   | d If Yes, Give<br>Year or Dat                        | es:  |   | 1□Yes XXNo                                 | Specify:                     | :                          |                                | Specify:                          | Whit            | te  |
| 5-             | 72 h<br>'natu   | Completed           | 15. Deceder<br>(Specify only highe  | nt's Education<br>est grade completed)               |  | (Give                                   | dent's Usual Occu                          | durina mos                   | st of worki                | ng                             | 16b. Kind of Bus                  | iness/Indu      | stry  |
| 121            | within<br>ene.<br>than "  | m                   | Elementary/Secondary (0-12)   | College (1-  |  | DO NOT use retire                       | ∍ <i>d)</i>                                |                              |                            | D11-+                          |                                   | 0               |   |
|                | filed withi<br>Hygiene.<br>other than   |                     |   | ( oat)   |  | Lab                                     | orer                                       | 10 Marsh                     |                            | (Since Adiabatic               | Blacktop                          | <u> </u>        | Company                                     |
| Maryland       | ould be fi<br>Mental H<br>arked ot<br>atic ever   | Be                  | 17. Father's Name (First, Middle, Carl Wiles  | , Last)  |  |   |  | 18. MOth                     |                            |                                | <i>Maiden Sumame</i><br>Cettermar | ,               | ے   |
| ž              | should Ind Men  | ٦<br>٢              |   | ohin (Time Brief)                                    |  | 105 14-15                               | Add /Ca                                    |                              |                            |                                |                                   |                 |   |
| Ma             | 12 sho<br>h and<br>7 is mu<br>traum   |                     | 19a. Informant's Name/Relation Carol A. Eyle  |  |  |   |  |                              |                            |                                | er, City or Town, S<br>Maryland   |                 |   |
| _              | 1 and<br>Health<br>em 27  |                     | 20a. Method of Disposition  |  | 20b. P                                       | lace of Dispo                           | osition (Name of                           | - 10                         | C                          | ate                            | 20c. Location - C                 |                 |   |
| Baltimore      | 8 2 = 5   |                     | XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3   |  | tate Mt.                                     |   | tarcemete:                                 | ry May                       | 25,                        | 2006                           |                                   |                 | 1701 21701                                  |
| Ball           | pernit. Pa<br>Departmen<br>Important:<br>any injury once  |                     | 21. Signaturi of Funeral Service  | MR Des   | fa Noto                                      | 003 K                                   | 2. Name and Addr<br>eeney and<br>06. Fast  | d Racf                       | Ford                       | Funeral                        | Home                              | MD 3            | 21701                                       |
|                |   |                     | 23a. Part1. Enter the disease, o shock, or heart failure. Lis   | or complications that calls tonly one cause of calls | used the death                               | h. Do not ent                           | ter the mode of dy                         | ing, such as                 | cardiac                    | r respiratory ar               | rest,                             | A Ir            | 21701<br>Approximate<br>nterval Between     |
| N.             | Physician   |                     | Immediate Cause (Final disease or condition   |  | IVer   |   | tails                                      | NVQ                          | [€                         |                                | lisease                           |                 | Druet and Death                             |
|                | /Medical  |                     | resulting in death)   | Due to (o  | r as a conseq                                |   | 0 1  | _                            | 1                          | 1 4 5 1 0                      | ,,, code                          | -)              | ) vo cue                                    |
|                | Examiner  |                     | Sequentially list conditions b. Heyato Kenal Syndrome bleed   |  |  |   |  |                              |                            |                                | edir                              | . Line ele      |   |
| 16%            |   | ner                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  Due to (or as a consequence of):  With (1991) After the cause of the cause (Disease or injury) |  |  |   |  |                              |                            |                                | )                                 |                 |   |
| V              | cutec   | Examiner            | that initiated events   | ) a. He  | tar  | 4,7                                     | with                                       | G                            | YYA                        | 5150                           | , Ascit                           | es -            | 1204  |
| 0              | ate be executed<br>hysician and<br>the burial-transit   |                     | resutting in death) Last  | Due to (o  | raks a consequ                               | /                                       | 1  | 4                            |                            | C 1                            | (                                 | Inter           |   |
| 8760           | y y   | Physician/Medical   |   | d HP   | BULL   | - 41                                    | cep hal                                    | OVA                          | My                         | FLOAY                          | a STROCKEN                        | A LANGE         | 2   |
| 9              | ntifica<br>ing pl   | Med                 | IF FEMALE:  |  |  |   | <u> </u>                                   | H                            | CHOTTE!                    | ATION APPROV                   | ED 0-1                            |                 |   |
| Вох            | law requires that the death certific<br>as been signed by the attending p<br>2 should be detached for use as  | an/l                | 23b. Was decedent pregnant  | 23c. If yes, outco                                   | ome of pregna                                |   | Ectopic pregnanc                           | ev C                         | CERI                       |                                | 230. Date                         | of delivery     |   |
|                | e dea   | SICI                | in the past 12 months?<br>1 ☐ Yes 2 No  |  | nt at time of de                             |   | Other (specify)                            |                              |                            |                                | Mont                              | n Da            | ay Year                                     |
| P.O            | at the de<br>I by the<br>stached  | Ph.                 | 9 Unknown   |  |  |   |  |                              |                            | 1                              | _                                 |                 |   |
|                | es that<br>igned b  | þ                   | Part II. Other significant conditi  | ions contributing to dea                             | th but not resi                              | ulting in the u                         | nderlying cause gi                         | ven in Part I                | l.                         |                                | obacco use contrib                |                 |   |
| Vital Records, | w requir<br>been si<br>should   | Completed           | - Ceryny  | 108  | 100  | ~ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | 7  |                              |                            | 1 U Y                          | ′es 2□No 3                        | Probab          | oly 4 Unknown                               |
| ecc            | law r<br>as be  | pie                 | 41(ap   | ol ab  | rse  | 1                                       | linit                                      | dru                          | n ul                       | 24a. Was autop                 | an 24b. W                         | ere autopsy     | y findings available<br>pletion of cause of |
| <u> </u>       | The law<br>cate has<br>page 2 s   | 0                   |   |  |  | (                                       |  |                              |                            | perfo                          | rmed? de                          | ath?<br>☐Yes 2[ | □ No  |
| ita/           | Physician: Th<br>this certificate<br>ral director, pag  | Be (                | 25. Was case referred to medical examiner?  | al   |  |   |  | 26. Place                    | e of Death                 | (Check only o                  | _~                                |                 |   |
| of V           | hysic<br>his ce<br>I dire   | 10                  | 1 XYes 2 No   | Hospital:  | patient 2 🗆                                  | ER/Outpatier                            | nt 3□ DOA Ot                               | her: 4 🗆 Nu                  | ursing Hor                 | ne 5 🗆 Resid                   | lence 6 Other                     | (Specify)       |   |
| ם              | fter  | ü.                  | 27. Manner of Death<br>1∠Natural 5 ☐ Pendi  | 28a. Date of<br>(Mgnth,                              | Injury<br>Day Year)                          | 28b. Time o<br>Injury                   | f 28c. Inju                                | ry at                        | 2                          | 28d. Describe h                | now injury occurred               | d               |   |
| Division       | Attending r death. sctor: After by the funer  | Certification       | 2 ☐ Accident invest   | tigation 05/2  | 2006   |   | M 1 [                                      | Yes 2                        | No                         |                                |                                   |                 |   |
| ≅              | r Att   | tific               |   | mined 286. Mace C                                    | f injury - At ho<br>g, etc. <i>(Specif</i> ) | ome, farm, str<br>v)                    | eet, factory, office                       |                              | 2                          | 28f. Location (S               | Street and Number<br>vn, State)   | or Rural R      | loute Number,                               |
|                | ital or ris af  |                     |   |  |  |   |  |                              |                            | Tred                           | RTICK                             | Me.             | * wiel Holy                                 |
|                | Hosp<br>4 hou<br>Fune<br>ely fil  | edical              | (Check only 2 Medical   | ing Physicien: To the b<br>I Examiner: On the bas    | is of examina                                | wtedge, death                           | h occurred at the t                        | ime, date an<br>opinion, dea | nd ptace, a<br>ath occurre | and due to the o               | cause(s) and mani                 | ner as state    | ed H  |
|                | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu  | Med                 | oney  | and manne  | or stated.                                   |   |  |                              |                            |                                |                                   |                 |   |
|                |   | -                   | 29b. Signature and the of certific  | . 0 1/   | /  |   |  | Se number                    | 84                         | 1                              | 29d. Date signed                  | Month, Da       | y, rear)                                    |
| •              | 3   |                     | geore   | na of  | rone   | 1 mis                                   |  | 0618                         |                            |                                | 5/21/                             | 0 4             | 0   |
|                | in  |                     | 30. Name and address of person  | who completed cause                                  | -  | _                                       | Print) 74                                  | omas                         | To                         | hnc                            | Church                            | (10 R           | ? Frederick                                 |
| 2.             | 10  |                     | 31. Date filed (Month, Day, Year  | ) - //V  | gistrar's Signa                              |   | 0 / //                                     | ~//(v)                       | J 0                        | NOW                            | COMYI                             | TCD             | 1217027                                     |
|                | Sta<br>Registr  |                     | יווו לי לי מותו ליו ליווו   | 6  | K  | Corte                                   | ,  |                              |                            |                                |                                   |                 | 1   |
| 100            | self-con-   | 10.25               | 1111 1 1 7 11 11  | U Care State   | Jr4 /  | - The same                              |  |                              |                            |                                |                                   |                 |   |

|   |  |                | 1 - For<br>State<br>Registrar   | State of Ma                       | arylar     |                              | artment of I<br><i>rtificate of</i>    |                           |                      | giene 2 ()        | 06                   | 22565  |
|---|--|----------------|---|-----------------------------------|------------|------------------------------|--|---------------------------|----------------------|-------------------|----------------------|--|
|   | STATE OF ME  |                | Decedent's Name (First, Middle, Last)   |                                   |            |                              |  |                           | 2. Date of De        | ath               |                      | 3. Time of Death                               |
|   | Physic<br>/Medi  |                | Robert Cannon   |                                   |            |                              |  |                           | June                 | 28.2              | 006<br>Yeer          | 5:00 PM  |
|   | Exami  |                | 4a. Facility Name (If not institution, give s   | treet and number)                 |            |                              | 4b. City, Town, o                      | or Location of Deat       |                      | 4c. County        |                      |  |
|   |  |                | SALISBURY REHAB &   | NURSING (                         | CENT       | ER                           | SALISBUR                               | RY, MD. 2                 | 1804                 | WICO              | MTCO.                |  |
|   | Funeral  |                | 5. Social Security Number 6. Sex  | 7. Ag                             |            | last birthday)               | If Under 1 Year<br>Months Days         | If Under 24 Hrs           | 8. Date of Birt      | h                 |                      | lace (State or Foreign                         |
|   | Director   |                | 221-16-8459   | M 2□F                             | 79         | Yrs.                         | Monard Bayo                            | 110010                    | March 16             |                   | Del                  | aware  |
| 5-2   | and *  |                | Usual Residence of Decedent  10a. State 10b. County   |                                   | 10c. Cit   | y, Town or Lo                | ncation                                |                           |                      |                   | 1                    | 0d. Inside City Limits                         |
|   | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23a or 28a-f show<br>he Madical Exeminer must be notified at   | ō              | MD Wicomico   |                                   |            | Salish                       |  |                           |                      |                   |                      | 12X Yes 2 □ No                                 |
|   | the N  | Director       | 10e. Street and Number  | <u>'</u>                          |            | Dalis                        | 10f. Zip Code                          |                           |                      | 10g. Citizen of V | /hat Cour            |  |
|   | with   |                |   |                                   |            |                              |  |                           |                      | -                 |                      | ury?   |
| 2   | eath   | Funerai        | 200 Civic Avenue  | 12. Was Decedent                  | Ever in 11 | S 13                         | 2180                                   | 14<br>Hispanic Origin? (S | Specify Ves or No    | U.S.              |                      | an Indian,                                     |
| 0   | ter d  | Ë              | 1 Never Married 2 Marned  | Armed Forces?<br>1 ⊠ Yes 2 □ N    |            |                              | If Yes, specify Cub                    | an, Mexican, Puer         | to Rican, etc.)      | Blac              | k, White,            |  |
| 36  | urs af   | by             | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:    | WW         | II                           | 1□Yes 2⊠No                             | Specify:                  |                      | Specify           | Whi                  | .te  |
| Canc<br>21215-0036  | 2 hou  | ed             | 15. Decedent's Educ   | ation                             |            | 16a. Dece                    | dent's Usual Occup                     | pation                    |                      | 16b. Kind of Bu   |                      |  |
| 2 <del>2</del> | n n<br>Madi  | Completed      | (Specify only highest grade<br>Elementary/Secondary (0-12)  | College (1-4or 5                  | 5+)        | (Give                        | kind of work done DO NOT use retire    | during most of wo         | rking                |                   |                      | •  |
| 0 %   | d with<br>giene  | E              | 8   | College (1-40)                    | )+)        | Mach                         | nine Oper                              | ator                      |                      | Nylo              | n Com                | pany   |
|   | ould be filed<br>Mental Hygi<br>arked other<br>atic event,   | Be C           | 17. Father's Name (First, Middle, Last)   |                                   |            | -                            |  | 18. Mother's Nar          | me (First, Middle,   | Maiden Sumam      | e)                   |  |
| 4   | Mental<br>Mental<br>rked c   | To B           | Robert Cannon   |                                   |            |                              |  | Cora                      | Mae Scot             | t                 |                      |  |
| ary   | 2 should I<br>and Meni<br>is marked  | -              | 19a. Informant's Name/Relationship (Type  | oe, Print)                        |            | 19b. Mailir                  | ng Address (Street                     | and Number or Ru          | ıral Route Numbe     | ar, City or Town, | State, Zip           | Code)  |
| S   | s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hyglene. Ifem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at |                | Eleanore Duncan   | (Daughte                          | er)        | 3510                         | )2 Blosso                              | m Court                   | Pittsv               | ille, M           | 21                   | 850  |
| Robert<br>altimore, Maryland  | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if item 27 is marked other than any injury or other traumatic event, the Maonce.   |                | 20a. Method of Disposition  |                                   | 20b. F     | Place of Dispo               | sition (Name of<br>natory or other pla | ce) T                     | Date                 | 20c. Location -   | City or To           | wn, State                                      |
| ~ ₽   | permit. Pages<br>Department of I<br>Important: if it,<br>any injury or o   |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐ R<br>4 ☐ Donation 5 🐼 Other (Specify)                                  | emoval from State                 |            | -                            |  | . Data                    | 3, 2006              | Hebroi            | ı. Ma                | ryland   |
| T I   | permit. I<br>Departm<br>Importar<br>any inju   |                | 21. Signature of Funeral Service License  |                                   | CPF-       |                              | 2. Name and Addre                      |                           |                      | nebroi            | 1, 110               | I y Lana                                       |
| m   | Per  |                | Figures.  | · ,                               |            | Şļ                           | nort Fune<br>B E. Grov                 | ral Home                  | elmar, D             | E 1994(           | 1                    |  |
|   | (list)   |                | 23a. Part1. Enter the disease, or complete shock, or heart failure. List only on                    | ations that caused                | the deat   | h. Do not ent                |  |                           |                      |                   |                      | Approximate                                    |
|   | Dhusisian  |                | Immediate Cause (Final  | e cause on each lin               | ne.        |                              | 1                                      | Dinea                     |                      |                   |                      | Interval Between<br>Onset and Death            |
|   | Physician /Medical   |                | disease or condition resulting in death)  | Due to (or as                     | 2000000    | uence of):                   | 7                                      | 1200                      | 30                   |                   | ن                    | 101-   |
|   | Examiner   |                |   | 500 20 (6) 23                     | a 0011300  | dence or,                    |  |                           |                      |                   |                      |  |
| 70.00   |  | ē              | Sequentially list conditions, if any, leading to immediate  | Due to (or as                     | a conseq   | uanca of):                   |  |                           |                      |                   |                      |  |
|   | uted<br>d<br>ansit   | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |                                   |            |                              |  |                           |                      |                   |                      |  |
| ć   | be executed<br>ician and<br>burial-transit   | Exa            | resulting in death) Last  | Due to (or as                     | a conseq   | uence of):                   |  |                           |                      |                   |                      |  |
| 8760,   | cate be ex<br>physician<br>the buria   | dical          |   |                                   |            |                              |  |                           |                      |                   |                      |  |
| .89   |  | . 0            |   |                                   |            |                              |  |                           |                      |                   |                      |  |
|   | ath certif<br>attending<br>for use as  | N              | IF FEMALE: 23b. Was decedent pregnant 23  | 3c. If yes, outcome               |            |                              | -                                      |                           |                      | 23d. Date         | of delive            | ry   |
| m   | death<br>atte  | cia            | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 1 ☐ Live birth<br>4 ☐ Pregnant at |            |                              | Ectopic pregnancy Other (specify)      | y<br>                     |                      | Mor               | ith                  | Day Year                                       |
| 0   | t the de<br>by the<br>tached   | nys            | 9 Unknown   | 9□ Unknown                        |            |                              |  |                           |                      |                   |                      |  |
| Division of Vital Records, P.O. Box   | res that<br>signed to<br>be deta   | by Physician/M | Part II. Other significant conditions con   | tributing to death b              | ut not res | ulting in the u              | nderlying cause giv                    | ven in Part I.            | 23e. Did to          | bacco use contr   | ibute to th          | e cause of death?                              |
| ds  | pures  |                |   |                                   |            |                              |  |                           | 1 🗆 Y                | es 2 No           | 3 🗌 Proba            | ably 4 Unknown                                 |
| Ō   | w require<br>been signal   | Completed      |   |                                   |            |                              |  |                           | 24a. Was             | an 24h V          | lere autor           | sey findings available                         |
| Be  | he la<br>has<br>ge 2   | E              |   |                                   |            |                              |  |                           | autop                | sy p              | rior to con<br>eath? | osy findings available<br>apletion of cause of |
| TO  | ician: Th<br>certificate<br>rector, pag  |                | OF Was asserted to madical  |                                   |            |                              |  |                           |                      |                   | Yes                  | 2 No   |
| ₹   | ysician: The<br>is certificate hi<br>director, page  | o Be           | 25. Was case referred to medical examiner?  1 Yes 2 D No  | ospital:                          |            | 50.0                         | t 3CT DOA Ott                          |                           | ath (Check only or   |                   |                      |  |
| of  | Phys<br>ratidi   | <b> -</b>      | 27. Manner of Death   | 28a. Date of Inju                 |            | ER/Outpatier<br>28b. Time of | I JU DON                               | 4 Warran Siriy i          | lome 5 Resid         | ow injury occurre |                      | )  |
| uo  | ding l<br>h.<br>After<br>funer   | Figure         | 1 ☐Natural 5 ☐ Pending  | 28a. Date of Injui<br>(Month, Day | ý Year)    | Injury                       | Wor                                    | rk?<br>Yes 2 ∐No          | 200. 200020          | ow injury cooding |                      |  |
| <u>:</u>  | ttendi<br>death.<br>ctor: A<br>y the fu  | Certification: | 3 Suicide 6 Could not be  | 28e. Place of Init                | urv - At h | ome farm str                 | eet, factory, office                   |                           | 28f Location (S      | treet and Numbe   | or or Rural          | Route Number                                   |
| S   | after<br>Dire  | erti           | 4 Homicide determined   | building, etc                     | c. (Specif | y)                           | out, radiory, office                   |                           | City or Tow          | n, State)         | , 0, 110, 2,         | riddig ridmoor,                                |
| _   | Hospital<br>24 hours a<br>Funeral I<br>tely filled   |                | 29a. Certifier 1 Certifying Phys  | ician: To the best                | of my kno  | wiedn death                  | a occurred at the time                 | mo, data and place        | and due to the       | sauco(a) and ma   |                      |  |
|   | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the   | Medical        | (Check only 2 Medical Exemir  | er: On the basis of               | f examina  | tion and/or in               | vestigation, in my o                   | ppinion, death occu       | irred at the time, o | date and place, a | nd due to            | the cause(s)                                   |
|   | To the within 2 To the complet   | Me             | 29b. Signature and title of certifier   | 1                                 |            |                              | 29c. Licens                            | se number                 |                      | 29d. Date signed  | (Month. I            | Day, Year)                                     |
|   | U<br>8 ± ≤ H   |                | I wit filet   |                                   |            |                              | 0                                      | 0 -                       | 9                    | 4/29              | 10                   | J/   |
|   | D. May   |                | 11111111  | ور بی                             |            | - 00-1 7                     |  | 0/39                      |                      | 101               | 166                  |  |
|   | du'n,  |                | 30. Name and address of person who co WILLIAM ROBINS, M.  |                                   |            |                              |  | v. Mn '                   | 21804                | ,                 |                      |  |
|   | ***  | )<br>oto       | 31. Date filed (Month, Day, Year)   | 32. <b>F</b> egistra              |            |                              | NUTODUK                                | T   CID+ 4                | ~1004                |                   |                      |  |
|   | Regist   | ate<br>rar     | JUL 0 3 20  | 06                                |            | 1. A                         | meter                                  |                           |                      |                   |                      |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Month **Physician** 8:25<sup>p</sup> Julia Esther June 23 2006 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Collingswood Nursing & Rehab. Rockville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 M 2 F Director 86 21, 1919 Washington, DC 578-14-9195 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, I'm Medical Examination as confident and once. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel West River 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20778 USA 1018 Shore Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: SpecifyWhite Yes. Give 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Stakem John Mewshaw 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1018 Shore Drive, West River, MD 20778 Thomas J. Clark, Jr./ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 29, 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State ^ 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2006 Alexandria, Virginia 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licens 500 University Blvd, W, Silver Spring, MD 20901 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rb. List only one cause on each line. 23a. Part1. Enter the dise shock, or heart failur Onset and Death Immediate Cause Finel **Physician** disease or condition resulting in death) Congestive Heart
Due to (or as a consequence of): Failure /Medical Examiner Sequentially list conditions, if any leading Limited Secures. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acute Renal Failure Examiner The law requires that the death certificate be executed burial-transit and ue to or as a consequence o): Box 68760 attending physician Physiclan/Medical as the l IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Year ō Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) □Yes 2□No detached Division of Vital Records, P.O. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ф 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 1 Yes 2 (No 1 Yes I or Attanding Physician: after death. Diractor: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cthen: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospitel 24 hours a 1 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To tha I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H51280 June 26, 2006 30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print) M.D. 9715 Medical Center Drive, #201, Rockville, MD 20850 Anushiravan Dadgar, Year) 32 Registrar's Signature 31. Date filed (Month, Day, State 2006 Registrar

# MARJORIE CALLAGHAN

|             |  |   | 1 - State of Maryland / Depart Registrar Certif  | tment of Health and <b>I</b><br>ificate of Death                         |                        | giene2 ()<br>Reg. No.                            | 96                     | 22568  |  |  |  |  |
|-------------|--|---|--|--|------------------------|--|------------------------|--|--|--|--|--|
|             |  |   | 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Dea         |  |                        |  |  |  |  |  |
| н           | Physici  |   | Marjorie S. Callaghan  |  | JUNE                   | 2 <b>6</b>                                       | 2006                   | 8:25PM <sup>M</sup>                                |  |  |  |  |
|             | /Medic<br>Examin   |   |  | 4b. City, Town, or Location of Death                                     |                        | 4c. County                                       |                        | 0.23111  |  |  |  |  |
|             | LAGIIIII   | ٠.  | 28797 OUTRAM ST.   | EASTON   |                        | TALBOT   |                        |  |  |  |  |  |
|             | Funeral  |   |  | If Under 1 Year   If Under 24 Hrs.                                       | 8. Date of Birth       | 3  |                        | ece (State or Foreign                              |  |  |  |  |
|             | Director   |   | 144-14-9863 1 M 2 TSF 84 Yrs.  | Months Days Hours Min.   | (Month, Day<br>Sept. 1 | r, Year)   | Count                  | try)   |  |  |  |  |
|             |  |   | Usual Residence of Decedent  |  | sept. 1                | 0,1921   | Konde                  | island   |  |  |  |  |
|             | yland  |   | 10a. State 10b. County 10c. City, Town or Local  | tion   |                        |  | 10                     | Od. Inside City Limits                             |  |  |  |  |
|             | Mar<br>F-f   | to  | Maryland Talbot Easton   |  |                        |  |                        |  |  |  |  |  |
|             | 1288   | Director  | 10e. Street and Number   | 10f. Zip Code  |                        | 10g. Citizen of                                  | What Count             | try?   |  |  |  |  |
|             | 3a o   |   | 28797 Outram ST  | 21601  |                        | U.S.A.   |                        |  |  |  |  |  |
|             | ne 2   | Funerai   |  |  |                        |  | e - America            | an Indian  |  |  |  |  |
|             | ritar  | Fun   | Armed Forces? If Y  1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑No  | as Decedent of Hispanic Origin? (S)<br>es, specify Cuban, Mexican, Puert | Rican, etc.)           | Bla  | ck, White, e           |  |  |  |  |  |
| ဗ္ဗ         | Irs a  | þ   |  | Yes 2 No Specify:  |                        | Specif   | v: Whi                 | t o  |  |  |  |  |
| 21215-0036  | 2 hou  | Completed   | 15. Decedent's Education 16a. Deceder  | nt's Usual Occupation  |                        | 16b. Kind of B                                   |                        |  |  |  |  |  |
| 55          | in 7   | pie   | (Specify only highest grade completed) (Give kin   | nd of work done during most of wor<br>NOT use retired)                   | king                   |  |                        |  |  |  |  |  |
| 7           | with<br>iene.  | E   | Elementary/Secondary (0-12) College (1-4or 5+)  2 Homen  | nakor  |                        | Own H  | lomo                   |  |  |  |  |  |
| 0           | Hyg<br>Hyg<br>other  |   | 17. Father's Name (First, Middle, Last)  |  | ne (First, Middle,     |  |                        |  |  |  |  |  |
| Maryland    | d be<br>ental<br>ked k   | To Be   | John H. Sullivan   | Mary M   | cCabe                  |  |                        |  |  |  |  |  |
| ₹           | shoul<br>nd Me<br>mari   | -   |  | Address (Street and Number or Ru   |                        | r City or Town                                   | State Zin              | Codel  |  |  |  |  |
| Š           | d 2 strau  |   |  |  |                        |  |                        | 0000)  |  |  |  |  |
| o,          | Heal<br>Heal   |   | Eugene F. Callaghan / Husband 28797  20a. Method of Disposition 20b. Place of Dispositi  | Outram ST Easton   |                        | 20c. Location -                                  |                        | vn State   |  |  |  |  |
| و           | 8 0 E 30   |   | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cremat   | tory or other place)   |                        |  | 1                      |  |  |  |  |  |
| Baltimore,  | permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or itame 23a or 28a-f show any injury and per traumatic event, it a Medical Exactinat natural transition at once.   |   | '4 □Donation 5 □Other (Specify) Arlington  | Nat'1 Cem. 07/1  | 9/06                   | Arlingt  | on, V                  | a.   |  |  |  |  |
| <u>ھ</u>    | Depariment of the popular in the pop |   | 21. Signature of Funeral Service Licensee 22. N  | Name and Address of Facility $ { m J}_{ m O}$                            | seph Gaw               | ler's S  | ons,                   | INC.   |  |  |  |  |
| _           | TO 2 6 0   | _   |  | 30 Wisconsin Ave   |                        |  | C.200                  | 16   |  |  |  |  |
|             |  |   | 23a. Part1. Enter the dispase, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. | the mode of dying, such as cardiac                                       | or respiratory arr     | est,   |                        | Approximate<br>Interval Between<br>Onset and Death |  |  |  |  |
|             | Physician  |   | disease or condition   |  |                        |  |                        |  |  |  |  |  |
|             | /Medical   | resulting in death)  Due to (or as a consequence of): |  |  |                        |  |                        |  |  |  |  |  |
|             | Examiner   |   | Sequentially list conditions, b.   | <u> </u>   |                        |  |                        | ,  |  |  |  |  |
|             | ם ב  | Examiner  | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying  |  |                        |  |                        |  |  |  |  |  |
|             | nd<br>rrans  | E   | Cause (Disease or injury that initiated events c.  |  |                        |  |                        |  |  |  |  |  |
| Ó,          | e exe<br>len a<br>urial-   |   | resulting in death) Last Due to (or as a consequence of):  |  |                        |  | F                      |  |  |  |  |  |
| 8760,       | icate be executed<br>physicien and<br>s the burial-transit   | dicai   | d  |  |                        |  |                        |  |  |  |  |  |
| 39          | ng pl  | 0 1   | IF FEMALE:   |  |                        |  |                        |  |  |  |  |  |
| Вох         | eath certific<br>attending p<br>for use as   | Jug   | 23b. Was decedent pregnanty  | ctopic pregnancy   |                        |  | e of deliver           | y  |  |  |  |  |
| Ξ.          | dea<br>ne att  | Physician/M   | 1 Yes 2 0 6 4 Pregnant at time of death 5 0  | Other (specify)  |                        | Mo   | nth [                  | Day Year   |  |  |  |  |
| o.          | that the de<br>led by the a<br>detached f  | h,  | 9 Unknown  |  |                        |  |                        |  |  |  |  |  |
| S,          | The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as  | by P  | Part II. Other significant conditions contributing to death but not resulting in the under   | erlying cause given in Part I.   | 23e. Did tob           | id tobacco use contribute to the cause of death? |                        |  |  |  |  |  |
| ë           | w require<br>been sig<br>should b  |   |  |  | 1 4                    | s 2 No   | 3 Proba                | bly 4 □Unknown                                     |  |  |  |  |
| Record      | sw requ  | Completed   |  |  | 24a. Was a             |  | Vere autop             | sy findings available                              |  |  |  |  |
| æ           | The law<br>ate has<br>page 2 s   | E   |  |  | autops                 | ned?   | prior to com<br>death? | pletion of cause of                                |  |  |  |  |
|             |  | e C   | 25. Was case referred to medical   | OC Place of Door   |                        |  | ☐ Yes 2                | ? L No   |  |  |  |  |
| >           | yslcian:<br>is certific<br>director,   | 0   | examiner?  | Other  | h (Check only on       |  | 10 (1                  |  |  |  |  |  |
| Division of | Attending Physician: r death. sctor: After this certific: by the funeral director.   | -   | 27. Manner of Death 28a. Date of Injury 28b. Time of   | 3 DOA 4 Nursing Ho   | 28d. Describe ho       |  | - ' ' ' ' '            |  |  |  |  |  |
| 0           | ding Ph<br>h.<br>After th<br>funeral   | tior  | 1 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐  | Work?<br>M 1 ☐ Yes 2 ☐ No  |                        | .,,  |                        |  |  |  |  |  |
| S           | or Attend<br>etter death<br>Director: A<br>in by the fi  | fica  | 3 Suicide 6 Could not be 290 Place of Lawre 4t home form street  |  | 28f. Location (St.     | reet and Numb                                    | er or Rural            | Route Number                                       |  |  |  |  |
| 2           | ette e   | Certification;  | 4 Homicide determined building, etc. (Specify)   | ,,   | City or Town           |  |                        |  |  |  |  |  |
|             | apita<br>ours<br>neral<br>tillec   |   | 29a. Certifier 1 ertifying Physicien: To the best of my knowledge, death or  | coursed at the time, date and place                                      | and due to the co      | ausa(s) and ma                                   | nner se ets            | tad  |  |  |  |  |
|             | Ho<br>24 h<br>Fur<br>etely   | edicai  | (Check only 2 Medical Examiner: On the basis of examination and/or invesore)   | red at the time, da  | ate and place, a       | and due to t                                     | he cause(s)            |  |  |  |  |  |
|             | To the Hospital or At within 24 hours etter of To the Funeral Direct completely tilled in by   | Me  | 29b. Signature and title of certifier  | 29c. License number  | 25                     | 9d. Date signed                                  | d (Month, D            | ay, Year)  |  |  |  |  |
|             | F ≱ F 8  |   | · Maria Mana   | 177,711  |                        | / -  | -                      |  |  |  |  |  |
|             | 30   |   | · may wan / w. morey /   | ) U31166   | 0                      | 62   | 1-06                   | 0  |  |  |  |  |
|             |  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Person VIII)   | ZON DAME   | ne de la               | 4,10   | anh                    | veda II  |  |  |  |  |
|             | -640   | 10  | 31. Date filed (Month, Day, Year)  32/Aegistrar's Signature  | 1000   | とうアレント                 | INGC   | n in i                 | vedgeM)  |  |  |  |  |
|             | Sta<br>Registr   |   | JUN 3 0 2006 1000 15 April   | w  |                        | -  |                        | 0  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                           |   |                     | 1 - For<br>State<br>Registrar   |  | - State of Ivia  | ii ylario                   | Cer                            | tificate                            | of De                     | eath  | - INIEIIIAI II                        | Reg. N                     |                            | 15                                 | 22569  |
|---------------------------|---|---------------------|---|--|--|-----------------------------|--------------------------------|-------------------------------------|---------------------------|---|---------------------------------------|----------------------------|----------------------------|------------------------------------|--|
|                           | Physici   |                     | 1. Decedent's Name FRANK  | (First, Middle, Las<br>TARR CA         | •  |                             |                                |                                     |                           |   | 2. Date of D                          |                            | ay 7                       | Year                               | 3. Time of Death                                 |
|                           | /Medio<br>Examir  |                     | 4a. Facility Name (If r   | not institution, give                  | street and number)   |                             |                                | 4b. City, T                         | own, or Lo                | cssA  | nne                                   | 4                          | c. County o                | of Death                           | +  |
|                           | Funeral<br>Director   |                     | 5. Social Security Nur<br>217-05-9  | 668                                    | 7. Age   | (In yrs. la                 | st birthday)<br>Yrs.           | If Under 1<br>Months                |                           | f Under 24 Hrs<br>Hours Min                   |                                       | Birth Cary Year            | 907 <sub>M</sub>           | 9. Birthplac<br>Country<br>[aryl   | ce (State or Foreign<br>')<br>and                |
|                           | yland   |                     | Usual Residence of D<br>10a. State  | 10b. County                            |  | 10c. City,                  | Town or Loc                    | ation                               |                           |   |                                       |                            |                            | 10d                                | . Inside City Limits                             |
| 21215-0036                | he Mar<br>28a-1 s   | ector               |   | Worcest                                | er   | Pocc                        | moke                           |                                     |                           |   |                                       | 10-0                       | (A) / 1A f                 |                                    | 1 XYes 2 □ No                                    |
|                           | 23a or 2  | rai Dir             | 32 Gree   |  | renue  |                             |                                | 10f. Zip (                          | 351                       |   |                                       | J                          | JSA                        | nat Country                        |  |
|                           | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If term 27 is marked other than "natural", or items 23e or 28e-f show eny injury or other traumatic event, the Medical Examinar must be invitiled at ance. | by Funeral Director | 11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4  |  | 12. Was Decedent E<br>Armed Forces?<br>1 ☑ Yes 2 ☐ N<br>If Yes, Give<br>Year or Dates: |                             |                                | Vas Decede<br>Yes, specr<br>☐ Yes 2 |                           | eanic Origin? (9<br>Mexican, Puer<br>Specify: | Specify Yes or Note Rican, etc.)      | No-                        | Black                      | - American<br>; White, etc<br>Whit | <b>.</b>   |
| 5-0                       | "natur  | ieted               | (Specify  | 5. Decedent's Ed<br>only highest gra   | ucation<br>de completed)   | 45                          | 16a. Deced                     | ent's Usual                         | Occupation done during    | on<br>ring most of wo                         | orking                                | 16b.                       | Kind of Bus                | iness/Indus                        | itry   |
| 2 5                       | d withir<br>giene.<br>Irre Ma   | Completed           | Elementary/Second   |  | College (1-4or 5   | +)                          | Farm                           |                                     | a reureuj                 |   |                                       | Agr                        | cicul                      | ture                               | :  |
| Maryland                  | uld be filed<br>Aental Hyg<br>rked othe   | To Be C             | 17. Father's Name (F<br>William   |  | s Carter   | •                           |                                |                                     |                           |   | me (First, Midd<br>irgini             |                            |                            | )                                  |  |
|                           | and 2 shoralth and N  |                     | 19a. Informant's Nan<br>James Ma  |  |  |                             |                                | ront                                | Str                       | eet, 1  | ural Route Nurr<br>POCOMO             |                            |                            |                                    |  |
| Ralfimore                 | Pages 1 ament of He ant: If Item ury or oth   |                     | 20a. Method of Dispo<br>1 Burial 2<br>4 Donation 5  | Date / 2006                            | 200, 2002, 300, 300, 300, 300, 300, 300,   |                             |                                |                                     |                           |   |                                       |                            |                            |                                    |  |
| 2 5                       | permit. Departulmport eny inj   |                     | 21. Signature of Fund   |  | Down   | 7                           | Ho                             |                                     | ay F                      | unera.  | Home                                  | -                          | Α.,                        | 103L                               | inden  |
|                           |   |                     | 23a. Part1. Enter the shock, or heart   | disease, or comp<br>failure. List only | olications that caused<br>one cause on each lin  | the death.<br>e.            | Do n Pen                       | como)                               | KRyin C.                  | and ardi                                      | 10 re 2118                            | 5 nust,                    |                            | In                                 | pproximate<br>iterval Between<br>inset and Death |
|                           | Physician<br>/Medical   |                     | Immediate Cause (Final disease or condition resulting in death)  a. CLOSTRIOIUM DIFFICILE COLITIS  Due to (or as a consequence of):                   |  |  |                             |                                |                                     |                           |   |                                       |                            | 15                         | 4                                  | DEERS  |
|                           | Examiner  |                     | Saturation list conditions b.   |  |  |                             |                                |                                     |                           |   |                                       |                            |                            |                                    |  |
|                           | ted<br>nsit   | niner               | if any, leading to imn<br>cause. Enter Underly<br>Cause (Disease or in  | nediate<br>ying<br>jury                | Due to (or as a consequence of):   |                             |                                |                                     |                           |   |                                       |                            |                            |                                    |  |
| _                         | icate be executed<br>physician and<br>s the burial-transit  | Examiner            | that initiated events resulting in death) Last Due to (or as a consequence of):  d.   |  |  |                             |                                |                                     |                           |   |                                       |                            |                            |                                    |  |
| 68760                     | rificate being physicias the bu   | dicai               |   |  |  |                             |                                |                                     |                           |   |                                       |                            |                            |                                    |  |
| Box                       | death certif<br>e attending<br>d for use a  | Physician/Me        | IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown   | nonths?                                | Ectopic pre<br>Other (spe  |                             |                                |                                     |                           | 23d. Date of delivery<br>Month Day Year       |                                       |                            |                            |                                    |  |
| 0                         | s that the ned by a detac   | by Ph               | Part II. Other signific   |  | ontributing to death bu  |                             | ting in the un                 | derlying ca                         | use given                 | in Part I.                                    | 23e. Dio                              | d tobacco                  | use contrit                | oute to the                        | cause of death?                                  |
| rds                       | w requires that been signed t   | ted b               |   |  | AIL URE  |                             |                                |                                     |                           |   | 10                                    | ]Yes 2                     | 2 □ No 3                   | Probab                             | ly 4 Donknown                                    |
| 200                       | has be  | Completed           |   |  | MELLI  |                             |                                | 772                                 |                           |   | 24a. Wa<br>aut<br>per                 | as an<br>topsy<br>rformed? | de                         | eath?                              | y findings available<br>letion of cause of       |
| 7                         | ician: The certificete herector, page   | a                   | 25. Was case referre  |  | BRILLA   | Ten                         |                                |                                     | 2                         | .6. Place of De                               | 1 ☐ Yes                               | 2 DN                       | 0 1[                       | Yes 24                             | □ No   |
| > 1                       | hysician;<br>this certific<br>al director,  | ToB                 | examiner?   | 6                                      |  |                             | R/Outpatient                   |                                     |                           |   | Home 5□Re                             |                            |                            |                                    |  |
| i                         | Attending Phys<br>r death.<br>sctor: After this o   | ation:              | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 ☐ Yes 2 ☐ |  |  |                             |                                |                                     |                           |   | 28d. Describ                          | e how inj                  | ury occurre                | d                                  |  |
| Division of Vital Becords | or Attence after death Director:  | Certification:      | 3 ☐ Suicide<br>4 ☐ Homicide   | 6 Could not be determined              | 28e. Place of Injubuilding, etc  | iry - At hon<br>. (Specify) | ne, farm, stre                 | eet, factory,                       | office                    |   |                                       | (Street a                  |                            | r or Rural R                       | Route Number,                                    |
|                           | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by  | Medical C           | 29a. Certifier<br>(Check only 2<br>one)   | Certifying Ph                          | ysician: To the best of niner: On the basis of and manner sta                          | examination                 | riedge, death<br>on and/or inv | occurred a estigation,              | t the time,<br>in my opin | date and place                                | e, and due to th<br>urred at the time | e, date ar                 | s) and man<br>nd place, ar | ner as state<br>nd due to th       | e cause(s)                                       |
|                           | To th<br>within<br>To th<br>compl   | Me                  | 29b. Signature and t  | the of certifier                       |  |                             |                                | 29c.                                | License n                 |   |                                       |                            | ate signed                 |                                    |  |
|                           |   |                     | 1   | > 6                                    | completed cause of de  | - al- /**                   | gg-1 /= -                      | 3                                   | 000                       | 06291   | +                                     | 1                          | nes                        | 03.                                | 2006   |
| BI                        | 79+1  |                     | SVETT AND   | 64716                                  | RAEZ 1   | 415                         | 5041                           | 77 19                               | 1015                      | 10~ 5   | WITE ?                                | z Sm                       | 215134                     | ny m                               | 0 21804  |
|                           | Sta<br>Regist   | ate<br>rar          | 31. Date filed (Month   | UL 0 3 2                               | 006 32. Bgistra  | ır's Signatı                | B 4                            | who                                 |                           |   |                                       |                            |                            |                                    |  |

|                     |   |                   | For State Registrer   | State o               | f Marylar                           | •   | artment of F                           |                   |                 | -                                      | giene<br>Reg. No. 20 (                    | 16 2                               | 2570            |  |  |
|---------------------|---|-------------------|---|-----------------------|-------------------------------------|---|--|-------------------|-----------------|--|---|------------------------------------|-----------------|--|--|
|                     |   |                   | 1. Decedent's Name (First, Middle   | , Last)               |                                     |   |  |                   |                 | 2. Date of De                          |   | 3. Tim                             | e of Death      |  |  |
|                     | Physicia<br>/Medic  |                   | Frances Louise  | Dewey                 |                                     |   |  |                   |                 | July 1                                 | •   | 7:30                               | $A^{M}$         |  |  |
| 3                   | Examin  |                   | As Maritha Maria (Maria Leak) attack and a street and a surface All City Town and a serious of I            |                       |                                     |   |  |                   |                 |  | 4c. County of                             |                                    |                 |  |  |
|                     |   |                   | Kline Hospice H   |                       |                                     |   | Mt. Airy                               |                   | 0411            |  | Freder                                    |                                    |                 |  |  |
| н                   | Funeral   |                   | 5. Social Security Number   | 6. Sex<br>1 ☐ M 2 🕱 F | 7. Age (In yrs.                     |   | If Under 1 Year<br>Months Days         | If Under<br>Hours | 24 Hrs.<br>Min. | 8. Date of Bir<br>(Month, Da<br>June 2 | th year)                                  | . Birthplace (Sta<br>Country)      |                 |  |  |
|                     | Director  |                   | 217-10-3329 Usuel Residence of Decedent   |                       | 9(                                  | 0 115.  |  | 1                 |                 | June 2                                 | 8, 1916                                   | 1916 Maryland                      |                 |  |  |
|                     | land  |                   | 10a. State 10b. County  |                       | 10c. Ci                             | ty, Town or Lo  | ocation                                |                   |                 |  |   | 10d. Inside                        | e City Limits   |  |  |
|                     | Mary  | ŏ                 | Maryland Washington Hagerstown  |                       |                                     |   |  |                   |                 |  |   | 1 □X                               | es 2 No         |  |  |
|                     | 1he   | Directo           | 10e. Street and Number  | 9                     |                                     |   | 10f. Zip Code                          |                   |                 |  | 10g. Citizen of What Country?             |                                    |                 |  |  |
|                     | 3a o  | ā                 | 1034 Brinker I  |                       |                                     | A.  |  |                   |                 |  |   |                                    |                 |  |  |
|                     | me 2  | Funerai           | 11. Marital Status  |                       | edent Ever in U                     | J.S. 13.  | Was Decedent of H                      | lispanic Ori      | igin? (Spe      | ecify Yes or No                        | 14. Race -                                | American Indian                    | 1,              |  |  |
| 9                   | or Ite  |                   | 1 Never Married 2 Marr  |                       | 2 X No                              |   | 1 ☐ Yes 2X No                          | Specify:          |                 | rican, etc.)                           |   | White, etc.                        |                 |  |  |
| 8                   | 4 within 72 hours after death with the Maryland<br>jiene.<br>r than "naturel", or Iteme 23a or 28a-f ehow<br>the Medical Examinar must be notified at   | d by              | 3 X Widowed 4 ☐ Divorced  | Year or D             | ates:                               |   | 103 22010                              | эрвспу.           |                 |  | Specify:                                  | White                              |                 |  |  |
| 5                   | 72 h<br>'natu   | Completed         | 15. Deceden<br>(Specify only highes   |                       |                                     | 16a. Decedent's Usual Decupation (Give kind of work done during m |  |                   |                 | ng                                     | 16b. Kind of Busin                        | Kind of Business/Industry          |                 |  |  |
| 121                 | within<br>ene.<br>then  | g.                | Elementary/Secondary (0-12)   | College (1            | 1-4or 5+)                           | DO NOT use retired<br>amstress                                    | 3)                                     |                   |                 | Fürnitu                                |   |                                    |                 |  |  |
| 2                   | 9 × 5 ÷   |                   | 17. Father's Name (First, Middle,   | ( act)                |                                     | Sec   | imstress                               | 18 Mothe          | ar's Name       | /First Middle                          | , Maiden Sumame)                          | ire                                |                 |  |  |
| anc                 | S E D   | Be                | Luther McLi   |                       |                                     |   |  |                   |                 |  | Metzer                                    |                                    |                 |  |  |
| Ž                   | should<br>ind Men<br>ind marke  | ဥ                 | 19a. Informant's Name/Relations   |                       |                                     | 19h Maili   | no Address (Street                     |                   |                 |  | er, City or Town, Sta                     | ate Zin Code                       |                 |  |  |
| Maryland 21215-0036 | 01 00   |                   | Sharon D. Clir  |                       | ca)                                 |   |  |                   |                 |  | rick, Mar                                 |                                    | 1701            |  |  |
| 45                  | s 1 end 2<br>if Health<br>Item 27 i   |                   | 20a. Method of Disposition  | ie (IVIC              |                                     |   | osition (Name of matory or other place |                   |                 | ate                                    | 20c. Location - Ci                        |                                    |                 |  |  |
| р                   | nt of<br>nt of<br>t: # lt   |                   | 1 ☐ Burial 2 X Cremation  |                       | State                               |   |  |                   |                 | y 4,                                   | Smithsbur                                 |                                    |                 |  |  |
| Baltimore,          | permit. Pages 1 Depertment of H Importent: If ite any injury or oti   |                   | 4 □ Donation 5 □ Other (S   |                       | Sm                                  |   | rg Cremat  2. Name and Addre           |                   |                 |  | Davis Fune                                |                                    |                 |  |  |
| Ba                  | Deperiment of the periment of |                   | 12525 Bradbury Ave. Smithsburg, Maryl   |                       |                                     |   |  |                   |                 |  |   |                                    |                 |  |  |
|                     |   |                   | 23a. Part1. Enter the disease, or   | complications that of | aused the dea                       |   |  |                   |                 |  |   | Approxi                            | mate            |  |  |
|                     |   |                   | shock, or heart failure. List only one cause on each line. Immediate Cause (Final                           |                       |                                     |   |  |                   |                 |  |   |                                    |                 |  |  |
|                     | Physician /Medical  |                   | disease or condition resulting in death)  | a                     | با                                  | eme   | my M                                   | 491               | VVS C           | pradu                                  | al aleu                                   | une                                |                 |  |  |
|                     | Examiner  |                   |   | Due to                | (or as a consec                     | quence of):   |  |                   | i               | 1                                      |   |                                    |                 |  |  |
|                     |   | ا <u>د</u>        | Sequentially list conditions, b. Due to (or as a consequence of):   |                       |                                     |   |  |                   |                 |  |   | _                                  | -               |  |  |
|                     | petr<br>Insit   | Examine           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury |                       |                                     |   |  |                   |                 |  |   |                                    |                 |  |  |
| Ć,                  | n and<br>ial-tra  | Exa               | that initiated events<br>resulting in death) Last   | C. Due to             | (or as a consec                     | quence of):   |  |                   |                 |  |   |                                    |                 |  |  |
| 8760,               | death certificate be executed<br>e attending physician and<br>nd for use as the burial-transit  |                   |   | d                     |                                     |   |  |                   |                 |  |   |                                    |                 |  |  |
| 9                   | ificat<br>g phy<br>as the   | edi               |   |                       |                                     |   |  |                   |                 |  |   |                                    |                 |  |  |
| Вох                 | n certifica<br>anding pt<br>use as th   | Physician/Medical | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, out      |                                     |   | 75                                     |                   |                 |  | 23d. Date of                              | of delivery                        |                 |  |  |
|                     | death<br>e atter  | Cia               | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4□Pregr               | ointh 2 □ Feta<br>nant at time of o |   |  |                   |                 |  |   | Month Day Year                     |                 |  |  |
| Ö                   | t the de<br>by the i  | h ys              | 9 Unknown   | 9□ Unkn               | own                                 |   |  |                   |                 |  |   |                                    |                 |  |  |
| G,                  | law requires that the<br>es been signed by th<br>2 should be detache  | by P              | Part II. Other significant condition  | ens contributing to d | eath but not re:                    | sulting in the u  | inderlying cause giv                   | en in Part I      |                 | 23e. Did t                             | obacco use contribu                       | ute to the cause                   | of death?       |  |  |
| ğ                   | w require<br>been sig<br>should t   | 9                 |   |                       |                                     |   |  |                   |                 | 10                                     | Yes 2 □ No 3                              | Probably 4                         | Unknown         |  |  |
| 000                 | aw request been 2 should  | piet              |   |                       |                                     |   |  |                   |                 | 24a. Was                               | an 24b. We                                | re autopsy findin                  | igs available   |  |  |
| Vital Records,      | 9 4 9   | Completed         |   |                       |                                     |   |  |                   |                 | perfo                                  | ormed? dea                                |                                    | Jr Cause of     |  |  |
| ita                 | lan: T<br>rtificet<br>stor, pa  | 0                 | 25. Was case referred to medica   |                       |                                     |   |  | 26. Place         | of Death        | (Check only o                          | 7   |                                    |                 |  |  |
| <b>*</b>            | yalc<br>lis ce<br>direc   | ToB               | examiner?   | Hospital:             | Inpatient 2                         | ER/Outpatie   | Other                                  |                   |                 |  |   |                                    |                 |  |  |
| n of                |   |                   |   |                       |                                     |   |  |                   |                 |  | how injury occurred                       |                                    |                 |  |  |
| Ö                   | Attending r death. ector: After by the fune   | atic              | 2 ☐ Accident investi  | ation                 |                                     |   |  | Yes 2 🗆           | No              |  |   |                                    |                 |  |  |
| Division            | or Attendation after death Director:  | Certification:    | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ  | ined 289. Place       | of Injury - At h                    |   | reet, factory, office                  |                   |                 | 28f. Location (:<br>City or To:        | Street and Number (<br>wn, State)         | or Rural Route N                   | lum <i>ber,</i> |  |  |
|                     | itat o  |                   |   |                       |                                     |   |  |                   | -               |  |   |                                    |                 |  |  |
|                     | To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the   | edicai            | (Check only 2 Medical   | g Physicien: To the b | asis of examina                     | owledge, deat<br>ation and/or in                                  | h occurred at the tir                  | ne, date an       | nd place, a     | and due to the ed at the time,         | cause(s) and mann-<br>date and place, and | er as stated.<br>I due to the caus | e(s)            |  |  |
|                     | To the I<br>within 2<br>To the I<br>complet   | Med               | one) 29b. Signature and title of certifie   | /                     | ner stated.                         |   | 20c Licens                             | o number          |                 |  | 20d Data signed (                         | Month One Von                      | -1              |  |  |
|                     | S T S   |                   | 29b. Signature and title of certifie  | 0                     |                                     | $\sim$  | 29c. Licens                            | 050               | 1               |  | 29d. Date signed (/                       | /                                  | 7               |  |  |
| •                   |   |                   | Dw  | An                    | mi                                  |   | 200                                    | 651               | /               |  | 7-03-                                     | 06                                 |                 |  |  |
| SH                  | -0  |                   | 30. Name and address of person  | who completed caus    | se of death (Ite                    | 0   | Print)                                 | Α.Δ               | ~ 4             | 40                                     | C.D.                                      | 100                                | 112             |  |  |
| ۱۱رد                |   |                   | 31. Date filed (Month, Day, Year)   | 32 F                  | Registrar's Sign                    | ature   | 10-01                                  | ON                | 7               | 1000                                   | 1 news                                    | uch, 1                             | VIC             |  |  |
|                     | Sta<br>Registi  |                   | JUL 0   |                       | Sieve                               | D. 1  | parte                                  |                   |                 |  | F   | 1401                               |                 |  |  |

06-04506 Mary Davis

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day June 27, 2006 1400 hrs Medical Examiner Mary Alice Davis 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Temple Hills 2250 Afton Street If Under 1 Year If Under 24Hrs Date of Birth(MM/DD/YYYY) 9. Birthplace (State or ) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign SO. Caro Days Months Hours Director 04/22/1937 1 M 2 **X**F 69 146-28-4759 ina Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location Yes 2 X No Temple Hills or 28a-f show Maryland Prince George notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 20748 USA 2250 Afton Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, 11. Marital Status 12. Was Decedent Ever in U.S. Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X No Yes Specify: Black If Yes, Give Year Yes 2 X No specify: 3 X Widowed Divorced more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after rent of Health and Mental Hygiene.
ant: If item 27 is warked other than "natural", ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Medical 12th Special Investigator US Air Force 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Melvin Williams Ruth Todd Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ 3414 25th Ave. Melinda D. Simms/Daughter Temple Hills, MD. 20748 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Department of He Important: If it in injury or nther t Resurrection Cem. 1 X Burial 2 Cremation 3 Removal from State 7/6/06 Clinton, MD. 4 Domation 5 Other Specify. 22. Name and Address of Facility Geo. P. Kalas Funeral Home Signature of Funeral Service License plas 6160 Oxon Hill Rd. Oxon Hill Approximate Interval Between Onset and Part I Enter the disease, or lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** failure. List only one cause on each line /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical ling physician a UNPENDED AMENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Month Day Fetal death past 12 months' Pregnant at time of death Other (Specify, 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Diabetes mellitus 5 a Completed Division of Vital Records, 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of performed death? ✓ Yes 2 No 2 No 1 🗸 Yes 26 Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Other: A Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient ER/Outpatient 3 1 V Yes 2 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending Investigation Accident 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) within 24 hours at To the Funeral D determined (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie June 28, 2006 O.C.M.E. e and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner 2. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/200 OCME 2006

State Registrar

ORIGINAL

| 06-04552 |  |
|----------|--|
|          |  |

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Dale Eugene Dunn 22573 1-For State
Registra Amend #4c. PerMEO PGC 7-3-0 Eprtificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1804 hrs Medical Examiner June 28, 2006 Dale Eugene Dunn 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) <del>Prince George's</del> Talbot Easton 45 Park Lane 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Director Country) Ohio Aug. 12,1926 Yrs 367-20-7830 1 X M 2 79 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a State 10h County 1 Yes 2 X No 28a-f show MD Talbot Easton hours after death with the Maryland Director 10g. Citizen of What Country? s 23a or 28a-f 10e. Street and Number 10f, Zip Code Park Lane 21601 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status or items White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes White If Yes, Give Year Yes 2 X No specify: Specify. 3 X Widowed 4 Divorced marked other than "natural", e event, the M dical Examiner ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036

t. Pages I and 2 should be filted within 72 h

trenet of Health and Mental Hygiene.

reant: If item 27 is marked other than "" 72 Draftsman / Engineer Westinghouse Corp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lulu G. Long David S. Dunn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Constance Myer / daughter 1237 Fairfax Ave. Churchton, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 3altimore, crematory or other place) other Burial 2 X Cremation 3 Removal from State ment c Metropolitan Crematory 07/07/2006 Alexandria, VA. Donation 5 Other Specify: 22. Name and Address of Facility Beall Funeral Home 21. Signature of Euneral Service Licensee Bowie, MD. 6512 NW Crain Hwy. 20715 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and cian/Medical AMENDED UNPENDED attending physician or use as the burial 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death Day Year 2 past 12 months? Pregnant at time of 5 Other (Specify) signed by the atte Physic 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been a ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 V N Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 V Yes 28a. Date of Injury (Month, Day, Year) After t 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death

Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: hin 24 hours after death.

Director: the Funeral D ٥

Certification:

Medical

State

Registrar

2

3

4

one)

1 V Natural

Accident

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

1111 0 3

30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner

Pending

Investigation

Could not be

and manner stated

32. Registrar's Signature

ORIGINAL

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

Yes 2 No

28f. Location (Street and Number or Rural Route Number, City

June 30, 2006

29d. Date signed (Month, Day, Year)

|   |  | 1- State<br>Registrar st.marysco.  |   | Ce   | rtificate o   | f Death  |  |  | . No.  |  |   |  |
|---|--|--|---|--|---|--|--|--|--|--|---|--|
| Physici   | ian  | Decedent's Name (First, Middle, Last)  |   |  |   |  |  | Date of Death<br>Month   | Day  | Year   | 3. Time of Death  |  |
| /Medi   | cal  | Sophia The 4a. Facility Name (If not institution, give s   |   |  | 4h City Town  | , or Location of   |  | July 9,  | 2006<br>4c. County   | of Death   | A W   |  |
| Examir  | ner  | 22680 Cedar Lane (   |   | 2109   | Leonar  |  | Dodin  |  |  | Mary'  |   |  |
| Funeral   |  | 5. Social Security Number 6. Sex   | 7. Age (Ir  | yrs. last birthday,  | If Under 1 Yea  | ar If Under 2  | 24 Hrs. 8.                                       | Date of Birth<br>(Month, Day, Y  |  | 9. Birthp  | place (State or Foreign   |  |
| Director  |  | 379−18−3800 <sup>1□</sup>  | ]M 2 <b>]</b> []F   | 84 Yrs.  | Months Day  | s Hours  | Min. De  | ecember 4  | ,1921  | Cour<br>Illi   | nois  |  |
| Hygiene<br>other then "natural", or iteme 23e or 28e-f show<br>ent, the Medical Exemple: The Trailified at  |  | Usual Residence of Decedent  10a. State 10b. County  | 10  | c. City, Town or L   | ocation   |  |  |  |  | 1  | Od. Inside City Limits  |  |
| Department of Health and Mental Hygiene. Important: if items 23s or 28s-f show important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Experiment must be notified at once. | ٥  | Maryland St. Mary  |   |  | nardtown  |  |  |  |  |  | 1 k∏ Yes 2 □ No   |  |
| 28a-  | Director   | 10e. Street and Number   | 5   | 13001  | 10f. Zip Code   | Э  |  | 10g  | . Citizen of \   | What Cour  | ntry?   |  |
| 38 04   | D  | 22680 Cedar Lane (   | Court. Apt.   | 2109   | 2065  | 50   |  |  |  | USA  |   |  |
| E E   | Funeral  |  | 12. Was Decedent Eve<br>Armed Forces?   |  | Was Decedent o  |  | gin? (Specif                                     | y Yes or No-   | 14. Rac  | can Indian,  |   |  |
| or its  |  | 1 ☐ Never Married 2 ☐ Married  | 1 ☐ Yes 2 🕅 No<br>If Yes, Give  |  | 1 ☐ Yes 2 🕅 N   |  | , Fuelto filo                                    | an, etc./  |  | Bfack, White, etc.  Specify:   |   |  |
| urel.   | d by   | 3 XWidowed 4 □ Divorced  | Year or Dates:  |  |   |  |  |  |  | Whi  |   |  |
| "nat  | Completed  | 15. Decedent's Edu<br>(Specify only highest grade  | cation<br>e <i>completed)</i>   | 16a. Dece<br>(Give   | dent's Usual Occ<br>kind of work dor<br>DO NOT use reti   | cupation<br>ne during most<br>ired)  | of working                                       | 16   | ib. Kind of B  | usiness/ind  | dustry  |  |
| The Man   | mo   | Elementary/Secondary (0-12)  | College (1-40r 5+)  |  |   |  |  |  |  | Home   | 2   |  |
| out,  | Be C   | 17. Father's Name (First, Middle, Last)  |   |  |   | 18. Mother   | r's Name (F                                      | First, Middle, Ma  |  |  |   |  |
| E C   | To B   | Anthony Bielawsk   | i   |  |   | Mar  | y Wie  | czerek   |  |  |   |  |
| n m   |  | 19a. Informant's Name/Relationship (Ty)  | rpe, Print)   | 19b. Mail  | ing Address (Stre   | et and Number  | r or Rural R                                     | Route Number, C  | City or Town,  | State, Zip   | Code)   |  |
| ar tra  |  | Laura Lee Pitzer   |   |  | 4 Buggs   |  |  |  |  |  |   |  |
| or of   |  | 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ A  |   | -  | matory`or other p   | olace)   | Date   |  | c. Location -  |  |   |  |
| jury  |  | 4 ☐ Donation 5 ☐ Other (Specify)   |   | Metropolit   |   |  | uly 10,  |  | lexandr  | ria, Vi  | irginia   |  |
| mpo<br>any ir   |  | 21. Signatule of Funeral Service License   | 16  | V M  | 2. Name and Add<br>attingley  | Gardiner   | Funer  | al Home,   | P.A.   |  |   |  |
|   |  | 23a. Part1. Enter the disease, or compli   | jeations that caused be   |  | O. Box 27   |  |  |  |  | ,  | Approximate   |  |
|   |  | shock, or heart failure. List only or<br>fmmediate Cause (Final  | ne cause on each line.  |  |   | , 3,   | 45   |  | ,  |  | Interval Between  |  |
| ician<br>dical  |  |  |   | C/_  | 1   | 10.  |  |  |  |  | Onset and Death   |  |
|   |  | disease or condition resulting in death)   | Due to (or as a co  | Stage:   | Linei   | Des  | las  | 2  |  |  | Onset and Death   |  |
| niner   |  | resufting in death)  | Due to (or as a co  | onsequence of):  | Linei   | Des  | las  | 2  |  |  | Onset and Death   |  |
|   | ner  | resufting in death)  | Due to (or as a co  | onsequence of):  | Linei   | Des  | las  | 2  |  |  | Onset and Death   |  |
|   | aminer   | resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | o. — Dua to (or as a so   | onsequence of):  | Linei   | Des  | las  | ٥  |  |  | Onset and Death   |  |
|   | il Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | 0   | onsequence of):  | Liner   | Des  | las  | 2  |  |  | Onset and Death   |  |
|   | dical Examiner   | resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | o. — Dua to (or as a so   | onsequence of):  | Linei   | Des  | las  | 2  |  |  | Onset and Death   |  |
| pnysician and<br>s the burial-transit   | edical   | resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | Due to (or as a co  | onsequence of):  | Liner   | Des  | las  | 2  | 23d Da   | te of delive   |   |  |
| pnysician and<br>s the burial-transit   | edical   | resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  | o. — Dua to (or as a so   | onsequence of):  onsequence of):  orsequence of):  oregnancy  Fetal death 3(   | □Ectopic pregnar  | псу  | las  | 2  |  | te of delive   |   |  |
| pnysician and<br>s the burial-transit   | edical   | resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant   | Due to (or as a co  | onsequence of):  onsequence of):  orsequence of):  oregnancy  Fetal death 3(   |   | псу  | las  | 2  |  |  | ery   |  |
| priysicial and<br>s the burial-transit  | Physician/Medical  | resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No  | Due to (or as a co  | onsequence of):  onsequence of):  oregnancy  Fetaf death   | □Ectopic pregnar<br>□ Other (specify)   | ncy  | las  |  | Мо   | onth   | ery   |  |
| pnysician and<br>s the burial-transit   | by Physician/Medical                                       | Sequentially list conditions, if any, reading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 SNo 9 Unknown  | Due to (or as a co  | onsequence of):  onsequence of):  oregnancy  Fetaf death   | □Ectopic pregnar<br>□ Other (specify)   | ncy  | las  | 23e. Did tobac   | Мо   | inbute to th   | ery<br>Day Year   |  |
| should be detached for use as the burial-transit  | by Physician/Medical                                       | Sequentially list conditions, if any, reading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 SNo 9 Unknown  | Due to (or as a co  | onsequence of):  onsequence of):  oregnancy  Fetaf death   | □Ectopic pregnar<br>□ Other (specify)   | ncy  | las  | 23e. Did tobac<br>1 ☐ Yes<br>24a. Was an   | Mocco use cont   | inbute to the  | ory Day Year  ne cause of death?  pably 4 □Unknown  psy findings available  |  |
| should be detached for use as the burial-transit  | ompleted by Physician/Medical                              | Sequentially list conditions, if any, reading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 SNo 9 Unknown  | Due to (or as a co  | onsequence of):  onsequence of):  oregnancy  Fetaf death   | □Ectopic pregnar<br>□ Other (specify)   | ncy  | las  | 23e. Did tobac<br>1 ☐ Yes<br>24a. Was an<br>autopsy<br>performs  | Mo  cco use cont  2 □ No  24b.   | inbute to the  | ony Day Year  ne cause of death?  bably 4 □Unknown  psy findings available  mpletion of cause of                            |  |
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| al director, page 2 should be detached for use as the burial-transit  | To Be Completed by Physician/Medical                       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or as a cold.  Due to (or as a cold.  3c. If yes, outcome of particles of the cold.  4 Pregnant at time 9 Unknown  htributing to death but not be cold.   | onsequence of):  onsequence of):  oregnancy   Fetal death   3(   e of death   5(   ot resulting in the u  2   ER/Outpatie  | □Ectopic pregnar □ Other (specify) underlying cause (   | given in Part I.  26. Place  □ther: 4 □ Nur  | of Death (Crising Home                           | 23e. Did tobac<br>1  Yes<br>24a. Was an<br>autopsy<br>performe<br>1  Yes 20  | Mo  coo use cont  2 □ No  24b.  No  256  6 ★ 10th  | white to the state of the state | Day Year  ne cause of death?  bably 4  Unknown  psy findings available  mpletion of cause of  2  No                         |  |
| al director, page 2 should be detached for use as the burial-transit  | To Be Completed by Physician/Medical                       | resulting in death)  Sequentially list conditions, IT any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a cod.  Due to (or as a cod.  3.c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown  htributing to death but not be considered to the code of | onsequence of):  onsequence of):  oregnancy   Fetal death   3(   e of death   5(   ot resulting in the unit of the content of  | □Ectopic pregnar □ Other (specify)  underlying cause general according to the second  | given in Part I.  26. Place  □ther: 4 □ Nur  ijury at Vork? □ Yes 2 □ N  | of Death (Crsing Home 28c                        | 23e. Did tobac  1 Yes  24a. Was an autopsy performe 1 Yes  Check only one  XX Residence 5. Describe how  | Mo  2 No  24b.  No  6 6 6 10th  injury occurr  | were autoprior to cordeath?  In Yes  In (Specif)   | ery Day Year  ne cause of death?  pably 4 Unknown  psy findings available  mpletion of cause of  2 No                       |  |
| al director, page 2 should be detached for use as the burial-transit  | To Be Completed by Physician/Medical                       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   SNo 9   Unknown  Part II. Other significant conditions co | Due to (or as a co  | onsequence of):  onsequence of):  oregnancy  Fetaf death   3   e of death   5    ot resulting in the to  2   ER/Outpatie ear)   28b. Time early   At home, farm, st  | □Ectopic pregnar □ Other (specify)  underlying cause general according to the second  | given in Part I.  26. Place  □ther: 4 □ Nur  ijury at Vork? □ Yes 2 □ N  | of Death (Crsing Home 28c                        | 23e. Did tobac  1 Yes  24a. Was an autopsy performe 1 Yes  Check only one  XX Residence 5. Describe how  | Mo  2 No  24b. No  37  No  6 Alone injury occurrent  | were autoprior to cordeath?  In Yes  In (Specif)   | Day Year  ne cause of death?  bably 4  Unknown  psy findings available  mpletion of cause of  2  No                         |  |
| this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit   | Certification: To Be Completed by Physician/Medical        | resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a cold.   onsequence of):  onsequence of):  oregnancy   Fetal death   3   e of death   5   ot resulting in the understand of the content | DEctopic pregnar Other (specify)  underlying cause so ont 3 DOA of 28c. In M 1 treet, factory, office   | 26. Place Other: 4   Nur Nork?   | of Death (Casing Home 286)                       | 23e. Did tobac  1  Yes  24a. Was an autopsy performe 1 Yes 25  Check only one)  XX Residence of the control of  | Mo  2 No  24b.  No  24b.  No  6 6 10th  injury occurrent and Numberstare)  | were autoprior to cordeath?  In Yes  at (Specify red   | Day Year  ne cause of death?  pably 4  Unknown  psy findings available  mpletion of cause of  2  No  y)                     |  |
| this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit   | Certification: To Be Completed by Physician/Medical        | resulting in death)  Sequentially list conditions, IT any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2 No 9   Unknown  Part II. Other significant conditions conditions conditions conditions conditions conditions conditions are referred to medical examiner? 1   Yes   2 No   1   2   2   3   3   3   3   4   4   4   4   4   4   | Due to (or as a cold.  Due to (or as a cold.  3c. If yes, outcome of public pregnant at time.  9 Unknown  htributing to death but not | onsequence of):  onsequence of):  oregnancy   Fetal death   3   e of death   5    ot resulting in the teath   28b. Time of length   ear)   28b. Time of length   28b. Time of length   ear)   28b. Time of length   28b. Time of length   ear)   28b. Ti | Dectopic pregnar Other (specify)  anderlying cause of the second of the | given in Part I.  26. Place Other: 4 □ Nur alury at York? □ Yes 2 □ N  | of Death (Craing Home 28c)  28c  28c             | 23e. Did tobac  1  Yes  24a. Was an autopsy performed to the control one)  XX Residence only one)  Location (Stree City or Town, Stree  City o | Mo  2 No  24b.  No  24b.  No  6 6 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  | inibute to the strict of the s | Day Year  ne cause of death?  bably 4  Unknown  psy findings available  mpletion of cause of  2  No  y)                     |  |
| this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit   | ertification: To Be Completed by Physician/Medical         | resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a cod.  Due to (or as a cod.  3.c. If yes, outcome of particles birth 2 and a cod.  4 Pregnant at time 9 Unknown  httributing to death but not be a cod.  28a. Date of Injury (Month, Day Yes)  28a. Place of Injury building, etc. (5)   | onsequence of):  onsequence of):  oregnancy   Fetal death   3   e of death   5    ot resulting in the teath   28b. Time of length   ear)   28b. Time of length   28b. Time of length   ear)   28b. Time of length   28b. Time of length   ear)   28b. Ti | Dectopic pregnar Other (specify)  underlying cause of the second of the | 26. Place Other: 4   Nur lyork?   Yes 2   N  itime, date and y opinion, deatt  | of Death (Craining Home) 28c No 28f d place, and | 23e. Did tobace  1  Yes  24a. Was an autopsy performe 1 Yes  2 Check only one)  XX Resident 2 Describe how  Location (Street City or Town, Street Causation (Street City or Town, Street City or Town, | Mo  2 No  24b.   | when the toth of the tribute to the same of the tribute to the same of the tribute to the tribut | Day Year  Day Year  De cause of death?  Deably 4 Dunknown  Description of cause of 2 No    |
| or death.<br>•ector: After this certificate has been signed by the attending<br>by the funeral director, page 2 should be detached for use a  | edical Certification; To Be Completed by Physician/Medical | resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a cod.  Due to (or as a cod.  3.c. If yes, outcome of particles birth 2 and a cod.  4 Pregnant at time 9 Unknown  httributing to death but not be a cod.  28a. Date of Injury (Month, Day Yes)  28a. Place of Injury building, etc. (5)   | onsequence of):  onsequence of):  oregnancy   Fetal death   3   e of death   5    ot resulting in the teath   28b. Time of length   ear)   28b. Time of length   28b. Time of length   ear)   28b. Time of length   28b. Time of length   ear)   28b. Ti | Dectopic pregnar Other (specify)  underlying cause of the second of the | 26. Place Other: 4 \( \triangle \tri | of Death (Craining Home) 28c No 28f d place, and | 23e. Did tobace  1  Yes  24a. Was an autopsy performe 1 Yes  2 Check only one)  XX Resident 2 Describe how  Location (Street City or Town, Street Causation (Street City or Town, Street City or Town, | Mo  2 No  24b. No  24b. No  6 Significant Numbers and Numbers and Numbers and place,   | when the toth of the tribute to the same of the tribute to the same of the tribute to the tribut | Day Year  Day Year  De cause of death?  Deably 4 Dunknown  Description of cause of 2 No    |

Registrar

DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

JUL 1 0 2006

32. Pigistrar's Signature

|  |                | For<br>State<br>Registrar  | State of Maryland   | •                       | rtment of<br>tificate of           |  |                                      | giene<br>Reg. No        | 4000                                       | 22575   |  |  |  |
|--|----------------|--|---|-------------------------|------------------------------------|--|--------------------------------------|-------------------------|--|---|--|--|--|
| Physici  | an.            | 1. Decedent's Name (First, Middle, Last)   | 2001150   |                         |                                    |  | 2. Date of De<br>Month               | ath<br>Da               | y Year                                     | 3. Time of Death                                |  |  |  |
| /Medic   |                | ROSEMANY   | PENITO  | 1                       | th Oh Tour                         | and anotion of Dan                                   | 30                                   | . County of Deat        | 0040 M                                     |   |  |  |  |
| Examin   | er             | 4a. Facility Name (If not institution, give st   | 11 1 1  |                         | Berlin                             | or Location of Dea                                   | (r)                                  | 40                      | Workes ter                                 |   |  |  |  |
| Funeral  |                | 5. Social Security Number 6. Sex   | 7. Age (In yrs. last  | birthday)               | If Under 1 Year<br>Months Days     |  |                                      | th<br>v. Year)          |  | nplace (State or Foreign untry)                 |  |  |  |
| Director   |                | 220-60-0092  | M 2 🕮 79  | Yrs.                    | Widnins Days                       | Nouis Will   | Dec.14                               | i, 1                    | 926 Wash                                   | ington,DC                                       |  |  |  |
| land ow  |                | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, T  | own or Loc              | cation                             |  |                                      |                         |  | 10d. Inside City Limits                         |  |  |  |
| h the Marylan<br>r 28a-f show  | tor            | MD Worceste  | r Oce   | an Ci                   | ty                                 |  |                                      |                         |  | 1 □ Yes <b>②</b> □ No                           |  |  |  |
| th the or 28;  | Director       | 10e. Street and Number   |   |                         | 10f. Zip Code                      |  |                                      | 10g. Ci                 | tizen of What Co                           | untry?  |  |  |  |
| ath w  | rai            | 12809 Pintail Dr.  |   |                         | 2184                               |  | 2 - 4 M                              | US                      | 14 Dans Ama                                | dans to disc                                    |  |  |  |
| 72 hours after death with the Maryland<br>natural; or items 23s or 28s-f show<br>Lical Examination malified at   | by Funeral     | 11. Marital Status 1  Never Married 2 Married 3 Widowed 4 Divorced   | 2. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:          | If                      | Vas Decedent of<br>Yes, specify Cu | Hispanic Origin? (:<br>ban, Mexican, Pue<br>Specify: | Specify Yes or No<br>no Rican, etc.) | )-                      | 14. Race - Ame<br>Black, White<br>Specify: | hcan Indian,<br>a, etc.<br>Thite                |  |  |  |
| 2 hou  |                | 15. Decedent's Educ  | ation 1   | 6a. Deced               | ent's Usual Occu                   | upation  | orking                               | 16b. K                  | (ind of Business/                          | Industry  |  |  |  |
| _ <u>_</u>   | Completed      | (Specify only highest grade Elementary/Secondary (0-12)  | College (1-4or 5+)  |                         |                                    | e during most of wo<br>ed)                           | n kii i g                            | _                       |  |   |  |  |  |
| be filed within tal Hygiene. Id other than event, the M  |                | 17. Father's Name (First, Middle, Last)  |   | Uwne                    | r-Opera                            |  | me (First, Middle                    |                         | staurant<br>Sumama)                        |   |  |  |  |
| d be f<br>antal h<br>ced of  | o Be           | Cristoforo Niosi   |   |                         |                                    |  | a Paness                             |                         | , comano,                                  |   |  |  |  |
| d 2 should be filed within th and Mental Hygiene. 7 is marked other than traumatic event, the Me.  | To             | 19a. Informant's Name/Relationship (Typ  | or Town, State, Z   | (ip Code)               |                                    |  |                                      |                         |  |   |  |  |  |
|  |                | Michael P. DeVito  |   | 1282                    | 3 Pinta                            | il Dr., 0  | cean Cit                             | y . I                   | d. 2184                                    | 2   |  |  |  |
| 8 5 2 5  |                | 20a. Method of Disposition  1XXBurial 2 ☐ Cremation 3 ☐ Re   | moval from State cem  | etery, crem             | natory or other pl                 | ace)   |                                      |                         |  | Fown, State                                     |  |  |  |
| t. Pages<br>tment of l<br>tant: If it  |                | '4 ☐ Donation 5 ☐ Other (Specify)  | Suns  |                         |                                    | Park   7-3<br>ress of Facility Th                    |                                      |                         | lin, Md.                                   | omo   |  |  |  |
| permit. Page<br>Department of<br>Important: If<br>any injury or  |                | 21. Signature of Funeral Service License   | Y Dalor   |                         |                                    | lian St.,  |                                      |                         |  | one   |  |  |  |
|  |                | % a. Part1. Enter the disease, or complic  | unns that caused the ceath  |                         |                                    |  |                                      |                         | 27   | Approximate<br>Interval Between                 |  |  |  |
| Physician  |                | 2. Part 1. Enter the risease, or complicit insight that cause the coath Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear filture. List only on cause on each line.  Immediate Cause (Final disease or condition  a. LOND NAMY ALIEM DISEASE |   |                         |                                    |  |                                      |                         |  |   |  |  |  |
| /Medical   |                | resulting in death)  | Due to (or as a consequen   |                         |                                    | 4 10011-   |                                      |                         | -  | ( YEARS   |  |  |  |
| Examiner   | L              | Sequentially list conditions, b.   | -   | 7 /2/14-3               |                                    |  |                                      |                         |  |   |  |  |  |
| led<br>sit   | Examiner       | Sequentially list conditions, if any, leading to him ediats cause. Enter Underlying Cause (Disease or injury   | y, leading to him ediate  Se. Enter Underlying  se. Enter Underlying  se (Disease or injury |                         |                                    |  |                                      |                         |  |   |  |  |  |
| be executed sician and burial-transit  | Exan           | that initiated events c.<br>resulting in death) Last   | Due to (or as a consequen   | ice of):                |                                    |  |                                      |                         |  |   |  |  |  |
| The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit                     | dicail         | d  |   |                         |                                    |  |                                      |                         |  |   |  |  |  |
| ng ph  |                | IF FEMALE:   |   |                         |                                    |  |                                      |                         |  |   |  |  |  |
| teath certifical attending ph  | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?  | 3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de                                    | ath 3                   | Ectopic pregnan                    | су   |                                      |                         | 23d. Date of deli<br>Month                 | very<br>Day Year                                |  |  |  |
| that the deed by the a   | ysic           | 1 ☐ Yes 2 No<br>9 ☐ Unknown  | 4☐ Pregnant at time of deat<br>9☐ Unknown   | n 5L                    | Other (specify)                    |  |                                      |                         |  |   |  |  |  |
| signed by  | by Ph          | Part II. Other significant conditions con  | tributing to death but not resulting  | ng in the ur            | nderlying cause g                  | jiven in Part I.                                     | 23e. Did t                           | obacco                  | use contribute to                          | the cause of death?                             |  |  |  |
| w require<br>been sig  |                | NONE   |   |                         |                                    |  | 1 🗆                                  | Yes 2                   | □No 3□Pr                                   | obably 4 Unknown                                |  |  |  |
| law requas been 2 should   | ompleted       |  |   |                         |                                    |  | 24a. Was                             | psv                     | 24b. Were au                               | topsy findings available completion of cause of |  |  |  |
| The cate h   | Con            |  |   |                         |                                    |  | perfo                                | ormed?<br>2 <b>X</b> No | death?                                     | 2 🗆 No  |  |  |  |
| v ne<br>iician<br>certific   | Be             | 25. Was case referred to medical examiner?   | ospital:  |                         |                                    | thos   | ath (Check only o                    |                         |  |   |  |  |  |
| rthis and dis  | 1.70           | 1 ☐ Yes 2 ☐ No  27. Magner of Death  | 28a. Dite of Injury 28  | VOutpatien  Bb. Time of | t 3□ DOA 28c. Inj                  | 4 Li Nursing   | Home 5 Resi<br>28d. Describe         |                         |  | cify)   |  |  |  |
| ath.<br>r: Afte  | ation          | 1 Natural 5 Pending 2 Accident investigation   | (Month, Day Year)   | Injury                  |                                    | ork?<br>□Yes 2□No                                    |                                      |                         |  |   |  |  |  |
| To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Certification: | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At home building, etc. (Specify)                                     | e, farm, stre           | eet, lactory, office               | В  | 28f. Location (<br>City or To        | Street al<br>wn, Stati  | nd Number or Ru<br>e)                      | ral Route Number,                               |  |  |  |
| pital of urs af paral D  |                | 29a. Certifier 1 Certifying Phys   | isings. To the best of any knowled  | -d d                    |                                    | sino des pod plac                                    | a and due to the                     |                         | \  | alatad  |  |  |  |
| 24 ho<br>24 ho<br>Fun  | edical         |  | icien: To the best of my knowle<br>er: On the basis of examination<br>and manner stated.    | and/or inv              | restigation, in my                 | opinion, death occ                                   | curred at the time,                  | date an                 | d place, and due                           | to the cause(s)                                 |  |  |  |
| To the within To the comple  | Me             | 29b. Signature and title of certifier  |   |                         | 29c. Lice                          | nse number   | , /                                  | 29d. Da                 | ite signed (Month                          | n, Day, Year)                                   |  |  |  |
|  |                | W Kredy  | V   |                         | 20                                 | 0508   | 10                                   | 6                       | 130/06                                     |   |  |  |  |
| 3 5  |                | 30. Name and address of person who co  | mpleted cause of death (Item 2:   | 3a) (Type,              | Print)                             | 1 DR B   | C 1 1 1                              | 06                      | 7 10                                       |   |  |  |  |
|  | _              | 31. Date filed (Month, Day, Year)  | 32. Restrar's Signatur  | 1TCA                    | CI D VVA                           | 1 DIC D  | GLLIN                                | 1010                    | 1 2181                                     | ′ /   |  |  |  |
| Sta<br>Regist  |                | JUI 0 3 2  |   | K 4                     | breedle                            |  |                                      |                         |  |   |  |  |  |

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| Division of Vital Records, P.O. Box 68760, | ation or Attending Dhysician: The law requires that the death certificate be executed |
|  | 100   |
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|  |                | •  | <b>pe or Print in t</b><br>State of Marylar  | nd / Depa                  | artmen   | t of Health                    | and Me       | -                                |          | egibie.                                   | . 2007   |  |
|--|----------------|--|--|----------------------------|--|--------------------------------|--------------|----------------------------------|----------|---|--|--|
|  | 1              | State Registrar  |  | Ce                         | rtificate  | e of Death                     |              |                                  | g. No.   | 2006                                      | 225/6  |  |
| Physicia<br>/Medica  | n              | 1. Decedent's Name (First, Middle, Last)  Lorraine Flu   | uharty Den   | eau                        |  | -                              | 2            | Date of Death<br>Month           | 3 Day    | 200 G                                     | 3. Time of Death  1609 M                           |  |
| Examine  |                | 4a. Facility Name (If not institution, give stre   |  | _                          |  | Town, or Location              |              | L                                |          | ounty of Death                            | 70-  |  |
|  |                | THE MEMORIAL   |  | <del></del>                |  | L ASTON                        |              | . Date of Birth                  |          |   |  |  |
| Funeral<br>Director  |                | 5. Social Security Number  215-44-7129  G. Sex  1 M  Usual Residence of Decedent   | 7. Age (In yrs.  | 9 Yrs.                     | Months   | Days Hours                     | Min.         | (Month, Day,<br>)ec. 24          | , 1946   | 6 Mar                                     | place (State or Foreign<br>ntn)<br>y 1 a n d       |  |
| with the Maryland<br>or 28a-f show   |                | 10a. State 10b. County MD Caroline   |  | ty, Town or L              |  | reston                         |              |                                  |          | 10d. Inside City Limits<br>1 ☐ Yes 2 🛣 No |  |  |
| 3a or 28a  | ā              | 10e. Street and Number 22272 Havercamp   | Road   |                            | 10f. Zip   | Code 2165                      | 5            |                                  | -        | n of What Cou                             | -  |  |
| a 0 =  | by Funeral     | 11. Marital Status 12.  1 Never Married 2 Married 3 Widowed 4 Divorced   | Was Decedent Ever in U<br>Armed Forces?<br>1 _Yes 2 17 No<br>If Yes, Give<br>Year or Dates:    | I.S. 13.                   | S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1  Yes |                                |              |                                  |          | Race - Amer<br>Black, White<br>pecify: W  |  |  |
| vithin 72 hours<br>ne.<br>han "natural",   | Be Completed   | 15. Decedent's Educat<br>(Specify only highest grade of<br>Elementary/Secondary (0-12)   | ion  | (Give                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Homemaker   |                                |              |                                  |          | of Business/li                            | ndustry  |  |
| permit. Pages 1 and 2 should be filed within Department of Heelih and Mental Hygiene. Important: If Itam 27 is marked other than any injury or other traumatic avent, the Magnes.  | To Be Co       | 12   Homemaker   18. Mother's Name (First, Middle, Man James Merritt Fluharty, Sr. Betty Lou Wi  |  |                            |  |                                |              |                                  |          |   |  |  |
| and 2 shores to and N an |                | 19a. Informant's Name/Relationship (Type, Forrest Deneau/  |  |                            |  | (Street and Numb<br>avercam    |              |                                  |          |   |  |  |
| Pages 1 a<br>nent of Hee<br>int: If Itam<br>iry or othe  |                | 20a. Method of Disposition  1 🛣 Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)  | noval from State   | Place of Disponentery, cre | osition (Nar<br>omatory or o   | ne of<br>ther place)<br>r Cem. | Dat<br>07/08 |                                  |          | tion - City or T                          | own, State<br>Maryland                             |  |
| permit. P<br>Departme<br>Importan<br>any injur   |                | 21. Signature of Funeral Service Licensee  | en   |                            |  | 1                              |              |                                  |          |   | Home, P.A  |  |
| Physician  |                | 23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition                                  | tions that caused the deacause on each line.   | th. Do not en              | ,  | e of dying, such as            |              | espiratory arre                  | ıst,     |   | Approximate<br>Interval Between<br>Opset and Death |  |
| /Medical<br>Examiner   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intlated events  Due to (or as a consequence of): |  |                            |  |                                |              |                                  |          |   |  |  |
| ite be executed<br>sysicien and<br>he burial-transit   | cai            | d  |  |                            |  |                                |              |                                  |          |   |  |  |
| The law requires that the death certificate be executed as the bas been signed by the ettending physicien and bage 2 should be deteched for use as the burial-transi   | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  | . If yes, outcome of pregn<br>1 □ Live birth 2 □ Fet<br>4 □ Pregnant at time of<br>9 □ Unknown | al death 3                 | □Ectopic pi<br>□ Other (sp   |                                |              |                                  | 23       | d. Date of deliving Month                 | very<br>Day Year                                   |  |
| uires that t<br>signed by  | ۾              | Part II. Other significant conditions contrib  | buting to death but not re   | sulting in the I           | underlying o   | ause given in Part             | 1.           |                                  | acco use |   | the cause of death?                                |  |
| The law recate has bee bage 2 short  | Completed      | 0  |  |                            |  |                                |              | 24a. Was an autops: perform      | y .      | 24b. Were aut prior to co death?          | opsy findings available ompletion of cause of      |  |
| lan:<br>rtifice<br>ctor, p   | Bec            | 25. Was case referred to medical examiner?   |  |                            |  | 26. Plac                       | e of Death ( | Check only on                    | a)       |   | ~  |  |
| Attending Physician: r death. sctor: Atter this certifice by the funeral director,   | ို             | 1 ☐ Yes 2√ZNo Hos  | spital:Incatient 2 [<br>28a. Date of Injury<br>(Month, Day Year)                               | 28b. Time of Injury        | of 2   | 8c. Injury at<br>Work?         | 28           | 5 Reside                         |          |   | ify)   |  |
| 5 g t o  | Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At h<br>building, etc. (Spec  | nome, farm, s              | treet, factor  | 1 Tes 2                        |              | f. Location (Sti<br>City or Town |          | Number or Rui                             | ral Route Number,                                  |  |
| To the Hospitel within 24 hours a To the Funeral I completely filled   | edical C       |  | r: To the best of my kn<br>r: On the basis of examin<br>and manner stated.                     |                            |  |                                |              |                                  |          |   |  |  |
| o tha  | Me             | 29b. Signature and title of certifier  | . 1  |                            | 29   | . License number               |              | 29                               | 9d. Date | signed (Month                             | . Day. Year)                                       |  |
| - > - ō  |                | > L'aidyemor   | thom r   | ND                         | -  | DO57                           | 74           | 9 3                              | JUL      | 75  | 2006   |  |
|  |                | 30. Name and address of berton who com<br>DR. LAKSHMI VAI  | DYANATHAI  | V, 21                      | 9 S.   | DOS 7<br>Washing:              | ton St       | ., Eas                           | iton,    | Hd.                                       | 21601  |  |
| Stat<br>Registra   |                | 31. Date filed (Month, Day, Year)  | 32. Registrar's Sign   |                            | Conti  | ,                              |              |                                  |          |   |  |  |

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

|  |  | State of Maryland  | d / Department of Health an<br>Certificate of Death  | nd Mental Hygiene<br>Reg. No. 2                                   | 2006 22577   |  |  |  |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
|  | Physician  | Decedent's Name (First, Middle, Lest)     FLAINE MARIE ELLIS   |  | 2. Date of Death  Month Day  June 26, 2                           | 3. Time of Death<br>10:40 AM   |  |  |  |  |  |  |  |  |
| The same of the sa | /Medical<br>Examiner   | 4a Fecility Name (If not institution, give street and number)  | 4b. City, Towr   |   | county of Death  |  |  |  |  |  |  |  |  |
| age.   |  | 510 Birchleaf Avenue   |  | Pleasant  | P.G.   |  |  |  |  |  |  |  |  |
| В  | Funeral<br>Director  | 5. Social Security Number 6. Sex 1 M 2√2 F 6. Age (In yrs. la  |  | Min. 8. Date of Birth (Month, Day, Year) 08/26/1941               | Birthplace (State or Foreign Country)  Washington, D.C.                                |  |  |  |  |  |  |  |  |
|  | Jend 1   |  | , Town or Location   |   | 10d. Inside City Limits  |  |  |  |  |  |  |  |  |
|  | a-f sh   | MD P.G. Se   | eat Pleasant   |   | XXYes 2□No   |  |  |  |  |  |  |  |  |
|  | offer death with the Ma<br>w flome 23a or 28a-f s<br>cliner must be novified<br>Funeral Director   | 10e. Street and Number   | 10f. Zip Code<br>20743   | 10g. Citize   | on of What Country?  |  |  |  |  |  |  |  |  |
|  | me 234   | 510 Birchleaf Avenue  11. Marital Status 12. Was Decedent Ever in U.S  |  | ? (Specify Yes or No-   | I. Race - American Indian,   |  |  |  |  |  |  |  |  |
| 020  |  | Armed Forces?  1 Never Married 2 Narried   1 Yes | If Yes, specify Cuban, Mexican, I  |   | Black, White, etc. Specify: Black  |  |  |  |  |  |  |  |  |
| 2-0  | 72 ho  | 15. Decedent's Education<br>(Specify only highest grede completed)   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of<br>life. DO NOT use retired)  | f working   | d of Business/Industry   |  |  |  |  |  |  |  |  |
| 21215-0020   | ed within 72 hours e<br>lygiene.<br>Per than "natural", c<br>nt, in Medical Evar<br>Completed by   | Elementary/Secondary (0-12) College (1-4or 5+)   | Entrepreneur   |   | elf  |  |  |  |  |  |  |  |  |
| bu   | be filed<br>tel Hyg<br>d other<br>event,   | 17. Father's Name (First, Middle, Last)  | 18. Mother's   | s Name (First, Middle, Maiden S                                   | umame)   |  |  |  |  |  |  |  |  |
| Maryland   | Ment<br>Ment<br>Ment<br>Ment<br>Ment<br>Ment<br>Ment<br>Ment   | Edward Thompson  | SON  |   |  |  |  |  |  |  |  |  |  |
| <u>⊠</u>   | nd 2 sh<br>lith enc<br>27 la m<br>r traum  | 19a. Informant's Name/Relationship (Type, Print) Robert Ellis — Husband  | 19b. Mailing Address (Street and Number 510 Birchleaf Avenue   |   |  |  |  |  |  |  |  |  |  |
| ore,   | es 1 ar<br>of Hea<br>item;   | 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State   | ace of Disposition (Name of<br>emetery, crematory or other place)  | Date 20c. Loca  | ation - City or Town, State  |  |  |  |  |  |  |  |  |
| Baltimore,   | Pag<br>tment<br>tant: If   | 4 □ Donation 5 □ Other (Specify) Riv   | verdale Crematory  22. Name and Address of Facility  | 07/03/06 Riv  | erdale, Maryland   |  |  |  |  |  |  |  |  |
| Bal  | permit. Page<br>Depertment of<br>Important: If<br>any injury or<br>phos.   | 21. Signature of Funeral Service Licensee  | Freeman Funeral Se<br>ue; Riverdale, Mary  |   |  |  |  |  |  |  |  |  |  |
|  |  | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |  |  |  |  |  |  |
|  | Physician<br>/Medical  | Immediate Cause (Final disease or condition a NDN SMALL CELL LUNG CANCER   |  |   |  |  |  |  |  |  |  |  |  |
|  | Examiner   | Due to (or   | as a consequence of):  |   | 1  |  |  |  |  |  |  |  |  |
|  | executed in and inelations it  |  | ASISTO BRAIN es e consequence of):   |   |  |  |  |  |  |  |  |  |  |
| 0,   | icete be execui<br>physician and<br>s the buriel-trei<br>edical Exar   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  |  | į   |  |  |  |  |  |  |  |  |  |
| 68760,   | ificate be executed g physician and as the buriel-transit ledical Examir   |  | as a consequence of):  |   |  |  |  |  |  |  |  |  |  |
| Вох  | et the death certion of the death certion of the ettending leteched for use the Physician/M  | d  |  |   |  |  |  |  |  |  |  |  |  |
|  | he dea   | Part II. Other significant conditions contributing to death but not resu   | Iting in the underlying cause given in Part I.   |   | se contribute to the cause of death?   |  |  |  |  |  |  |  |  |
| s, P.O   | s that t   |  |  | 1 Yes 2   | No 300 Probably 4 □ Unknown  |  |  |  |  |  |  |  |  |
| cords  | The law requires that the death certificate has been signed by the ettending page 2 should be deteched for use e Compieted by Physician/M.                             |  |  | 24a. Was an autops<br>performed?                                  | y 24b. Were autopsy findings<br>available prior to<br>completion of cause<br>of death? |  |  |  |  |  |  |  |  |
| - Re   | The tay  |  |  | 1∐Yes 2 <b>X</b>  | No 1 ☐ Yes 2 ☐ No  |  |  |  |  |  |  |  |  |
| Vita   | clan:  | 25. Was case referred to medical examiner?   | Other  | f Death (Check only one)  | T01 (0 7)  |  |  |  |  |  |  |  |  |
| on of  | ling Phys  | 27. Manner of Death 1 Natural 5 Pending (Month, Dey Year)  | ER/Outpatient 3 □ DOA □ 00100. 4 □ Nurs  28b. Time of  | 28d. Describe how injury  |  |  |  |  |  |  |  |  |  |
| Division of Vital Records,   | or Attanding<br>efter death.<br>Director: After<br>d in by the fune  | 2□ Accident  | me, farm, street, factory, office  | 28f. Location (Street and<br>City or Town, State)                 | Number or Rurel Route Number,  |  |  |  |  |  |  |  |  |
|  | To the Hospital or Attending Pl<br>within 24 hours effer death.<br>To the Funeral Director: After the<br>completely filled in by the funeral<br>Medical Certification: | 29a. Certifier (Check only one) Medical Examiner: On the basis of examinat and manner stated.  | wledge, deeth occurred at the time, date and<br>ion end/or investigation, in my opinion, death   | place, and due to the cause(s) a occurred at the time, date and p | and manner as stated.<br>blace, and due to the cause(s)                                |  |  |  |  |  |  |  |  |
|  | vithin 2   | 29b. Signature and title of certifier  |  | signed (Month, Day, Year)   |  |  |  |  |  |  |  |  |  |
|  |  | Havani Comesse M.D   | D465=  | 16 6  | 129106   |  |  |  |  |  |  |  |  |
| N  | (5)  | 30. Name end address of person who complete cause of death (Item HAWANT TEMESGEN, 6104 0   | 238) (Type, Print) LD BRANCH AVENUE  | TEMPLE HILL   | MD, 20748  |  |  |  |  |  |  |  |  |
|  | State<br>Registrar   | 31. Date filed (Month, Day, Year)  111 0 3 2006  | and the second s |   |  |  |  |  |  |  |  |  |  |

DHMH 16 Rev 6/95

06-04514 Bria

# Please Type or Print in Black Indelible Ink

| Brian Eubanks   |                | State of Maryland / Departr<br>- For State Certifi   | ment of Health and Ment<br>icate of Death  |   | 2006 2257   |
|---|----------------|--|--|---|---|
| Physicia  | n/             | egistrar I. Decedent's Name (First, Middle,Last)   | Eubanka  | 2. Date of Death<br>Month<br>June 27, 20      |   |
| Medical Examin  |                | Brian Leroy  4a. Facility Name (if not institution, give street and number)  | Eubanks  4b. City, Town, or Location of  |   | 4c. County of Death   |
|   |                | 210 69th Street  | Seat Pleasant  |   | Prince George's   |
| Funeral<br>Director   |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last to 214-02-9290 134 2 F 34                                      | birthday) If Under 1 Year If U | Min   | 6, 1972 Seithplace (State or Foreign Country) Wash DC             |
| any   | T              | ,  | wn or Location   |   | 10d. Inside City Limits   |
| rland<br>-f show<br>once.   | Ē              | Maryland Prince George's   | Seat Pleasar   |   | 1 X Yes 2 No  |
|   | Dire           | 10e. Street and Number 210 69th Street   | 20743  |   | USA   |
| death wi  | Funeral        | 11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2 No  | 13. Was Decedent of Hispanic Orig  |   | White, etc.   |
| rs after<br>ural", c  | اھ             | 3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16 | 1 Yes 2 X No specify:  | Specify BIdCK  16b. Kind of Business/Industry |   |
| 72 hour   | Completed      | Elementary/Secondary (0-12)  College (1-4 or 5+) 2+  | during most of working life. DO NOT  | use retired)                                  |   |
| 0036<br>within<br>giene<br>her tha  | d wo           | 17. Father's Name (First, Middle, Last)  | Forklift Operat  | S Name (First, Middle, M                      | Private   |
| 215-0036<br>be filed within 7<br>nital Hygiene<br>riked other than  | Be C           | Leroy Eubanks  |  | Joyce Walke                                   | · · ·   |
| D 21<br>should I<br>nd Mer<br>is mar  | 2              |  | 19b. Mailing Address (Street and Num   |   | per, City or Town, State, Zip Code) Vashington DC 20019           |
| e, MD and 2 sho Health and item 27 is   | ŀ              | 20a. Method of Disposition 20b. Place  | ce of Disposition (Name of cemetery, matory or other place)  |   | 20c. Location - City or Town, State                               |
| MOF<br>Pages lent of l  |                | Burial 2 X Clemation 3 Removal non State   | apeake Crematory   | 7/1/2006                                      | Beltsville, MD  |
| Baltimore,<br>permit Pages 1 ar<br>Department of Hee<br>Important: If ite   |                | 21. Signature of Funeval Service Licensee  | 22. Name and Address of Facility 9013 Annapolis  | ·   |   |
| Physician   | $\dashv$       | 23a Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line. |  |   |   |
| /Medical<br>Examiner  | 1              | Immediate Cause (Final disease a Contact Gunshot Wound of  | of Head  |   | Death   |
|   |                | or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.                |  |   |   |
|   | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated                         |  |   |   |
| uted<br>Id<br>ransit  |                | events resulting in death) Last  Due to (or as a consequence of):  d.  |  |   |   |
| ),<br>be exec   | Medical        | UNPENDED AMENDED   |  |   |   |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit | ician/Me       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 ☐ Live birth   |  | c pregnancy                                   | 23d. Date of delivery  Month Day Year                             |
| Box 687 c death certific the attending p  | sicie          | 4 Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown   | 5 Other (Specify)  |   |   |
| P.O. E  | by Physic      | Part II. Other significant conditions contributing to death but not resu   | Iting in the underlying cause given in Pa  |   | pacco use contribute to the cause of death?                       |
| IS, P<br>quires then signer<br>and be d   |                |  |  | 1 Yes 24a. Was a                              | 2 No 3 Probably 4 ✔ Unknown  24b. Were autopsy findings available |
| COFC<br>law re<br>has be  | Completed      |  |  | autops perfore  1 ✓ Yes 2                     | med? death?   |
| al Re<br>an: The<br>ertificate<br>tor. pag  |                | 25. Was case referred to medical   | 26.Place of Death  |   | P. No 1 ✓ Yes 2 No  |
| F Vita  | To Be          | 1 V fes 2 No   | R/Outpatient 3 DOA Other,4  Bb. Time of Injury 28c. Injury at Work   |   | Residence 6 🗸 Other: Scene ow injury occurred                     |
|   |                | 1 Natural 5 Pending FO(Month Day, Year) F  | Bb. Time of Injury 28c. Injury at Work 1 Yes 2 4   | Subject shot                                  |   |
| Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:   | Certification: | 3 Suicide 6 Could not be 28e. Place of Injury - At home  | e, farm, street, factory, office building, et  | tc. 28f. Location (S<br>or Town, St           | treet and Number or Rural Route Number, City ate)                 |
| Di<br>Hospital<br>24 hours a<br>Funeral   |                | 4 Homicide determined (Specify) Home  29a. Certifier 1 Certifying Physician: To the best of my knowledge,            | death occurred at the time, date and ni-   |   | eet, Capitol Heights, MD  |
| To the H<br>within 24<br>To the F<br>complete   | Medical        | (Check only one) 2 Medical Examiner: On the basis of examination and/and manner stated.                              | or investigation, in my opinion, death or  | courred at the time, date a                   | and place, and due to the cause(s)                                |
| T % T %   | Me             | 29b. Signature and title of certifier  | 29c. License number<br>O.C.M.E.  |   | 29d. Date signed (Month, Day, Year)  June 28, 2006                |
|   |                | Theylur U Life and address of person who completed cause of death (Item 23   |  |   | 54.10 20, 2000  |
| urt   |                | Theodore King MD. Assistant Medical Examiner   | 111 Penn Street, Baltimore,  | MD 21201                                      |   |
| St<br>Regis   | tate<br>trar   | 31 Date filed (Month, Day, Year) 32 Registrar's Signature  | beech  |   |   |
| DHMH 17 Rev 1/2   |                |  | ORIGINAL   |   |   |

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 1.45A **Physician** John Elmer Eastridge JUL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LINION HOSPITAL OF CECIL COUNTY ELKTON Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1⊠M 2□F 219-05-8082 March 16,1923 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28e-f show the Medical Examinat must be notified at 1 □ Yes 2 No Perryville Cecil Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 21903 81 Patterson Avenue U.S.A. death v 12. Was Decedent Ever in U.S. Amed Forces? 1 ⊠ Yes 2 □ No If Yes. Give Year or Dates: 1943-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after at Hygiene. other than "natural", or ite 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Bainbridge Naval College (1-4or 5+) Elementary/Secondary (0-12) Training Center Planner & Estimator Twelve Years Bainbridge, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any lighty or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) David Andrew Eastridge Almar Lockey Roten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 131 Ash Lane, Elkton, Maryland 21921 Christopher J. Eastridge (son) 20b. Place of Disposition (Name of 20a Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/06/06 4 □ Donation 5 □ Other (Specify) Asbury Cemetery Port Deposit, Maryland 21. Sign Fure of Funeral Service Licenses 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 HEDDIN, Dr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EXACERBATION ysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner CORONARY ARTERY ed by the attending physicien and detached for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by I should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t autopsy performed, 1 Yes 2 No 1 Yes 2 No Hospitel or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pendina within 24 hours after death. To the Funeral Director: A 1 TYes 2 □ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onh 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2006 D0063486 30. Name and addre's of person who completed use of death (Item 23a) (Type, Print) 10+1VA STREET, ELKTON, MD BOW 106 32. Resistrar's Signature 31. Date filed (Month, Par Year) 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 115

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|-----|---|---|---|--------|
| Con | 6 | J | 8 | U      |

|            |  |   | For<br>State<br>Registrar  |                        | State of Mic  | liylariu                            |                                | tificate of   |                                     | I WICHTAI II                       | Reg. N             |                                     | 22300                                   |  |
|------------|--|---|--|------------------------|---|-------------------------------------|--------------------------------|---|-------------------------------------|------------------------------------|--------------------|-------------------------------------|---|--|
| e e        | 1.2  |   | Decedent's Name (First, M.   | iddle, La              | st)   |                                     |                                |   |                                     | 2. Date of D                       |                    | Day Yea                             | 3. Time of Death                        |  |
|            | Physicia<br>/Medic   |   |  | MARY                   | MARTHA EV   | ANS                                 |                                |   |                                     |                                    |                    | 2006                                | 2:30 P M                                |  |
|            | Examin   |   | 4a. Facility Name (If not instit   | ution, giv             | e street and number)  |                                     |                                | 4b. City, Town, o                                   | r Location of De                    | eath                               | 4                  | 4c. County of Death                 |   |  |
|            | ·<br>%   | Sept.   | NATIONAL NA  |                        |   |                                     |                                |   | HESDA                               |                                    |                    |                                     | TGOMERY                                 |  |
| 6.2        | Funeral  |   | 5. Social Security Number  | 6. 5                   | Sex 7. Age  | (In yrs. la                         |                                | If Under 1 Year<br>Months Days                      | If Under 24 H                       | in. 8. Date of B                   | irth<br>Day, Yea   | 9. B                                | irthplace (State or Foreign<br>Country) |  |
|            | Director   |   | 302-16-2075<br>Usual Residence of Deceden  |                        | - <b>X</b>  | 81                                  | Yrs.                           |   |                                     | Nov.                               | 21,_               | 1924                                | Ohio                                    |  |
|            | land   | }   | 10a. State 10b. Co   |                        |   | 10c. City,                          | Town or Loc                    | ation   |                                     |                                    |                    |                                     | 10d. Inside City Limits                 |  |
|            | Mary<br>f sho  | ō   | Maryland Mon   | tgom                   | ery   | Roc                                 | kville                         | <b>:</b>  |                                     |                                    |                    |                                     | 1 ☐ Yes 2 🙀 No                          |  |
|            | the 28s  | Directo   | 10e. Street and Number   |                        |   |                                     |                                | 10f. Zip Code                                       |                                     |                                    | 10g. (             | Citizen of What (                   | Country?                                |  |
|            | 3a or  |   | 12005 Rockin   | or Ho                  | rse Road  |                                     |                                | 20852   | -2352                               |                                    |                    | ,                                   | USA                                     |  |
|            | me 2   | Funerai   | 11. Marital Status   | 9_110                  | 12. Was Decedent I<br>Armed Forces?                             | Ever in U.S                         | . 13. W                        |   |                                     | (Specify Yes or Nerto Rican, etc.) | 10-                | _                                   | nerican Indian,                         |  |
| 215-0036   | within 72 hours after death with the Maryland<br>lene.<br>r than "natural", or Itame 23a or 28a-f show<br>the Madical Exandrar must be incitted at | by  | 1 Never Married 2 3 XWidowed 4 Divo  |                        | 1 Tyes 2 If Yes, Give Year or Dates:                            | lo                                  |                                | Yes 2 No  |                                     | ierto Aicari, etc.)                |                    | Specify:Wh                          |   |  |
| 5          | 72 ho  | ted   | 15. Dece   | dent's E               | ducation<br>ade completed)                                      |                                     | 16a. Deced                     | ent's Usual Occup                                   | pation<br>during most of            | workina                            | 16b.               | Kind of Busines                     | s/Industry                              |  |
| 7          | within 72<br>ene.<br>than "nai   | Completed   | Elementary/Secondary (0-   |                        | College (1-4or 5  | +)                                  | life. D                        | kind of work done<br>O NOT use retire               | d)                                  |                                    |                    |                                     |   |  |
| 7          | 9 0 6 .  | Cor   | 12   |                        |   |                                     | Неа                            | ad Bookke   |                                     | V                                  |                    |                                     | e Company                               |  |
| ב          | @ = >  | Be  | 17. Father's Name (First, Mic  |                        | •   |                                     |                                |   | _                                   | Name (First, Midd                  |                    |                                     | Weidenbell                              |  |
| <u> </u>   | should Ind Mening Marks  | ဥ   | Carl Gaylor  |                        |   |                                     | 40) 44-11                      | A 11 (Character)                                    |                                     |                                    |                    |                                     | na Weidenhell                           |  |
| , maryland | and 2 st<br>ealth and<br>m 27 is n   |   | 19a. Informant's Name/Related Sharon Lynn C  |                        |   |                                     | 12005                          | Rocking   | Horse 1                             |                                    | ckvi               | lle, MD                             | 20852-2352                              |  |
| Baltimore, | irmit. Pages 1 and 2 should be spartment of Health and Ments portent: If item 27 Is marked by injury or other traumatics.                          |   | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremat  4 ☐ Donation 5 ☐ Other  |                        |   |                                     |                                | sition (Name of<br>atory or other pla<br>morial Par | <sub>сө)</sub><br>k Ju              | Date<br>11y 6,<br>2006             | 1                  | Location - City of                  | or Town, Slate  Maryland                |  |
|            | mit. Foorten   |   | 21. Signature of Funeral Ser   |                        |   |                                     | F <sup>2</sup> Y               | Name and Addre                                      |                                     | ns Funera                          |                    |                                     | naryrana                                |  |
| ñ          | F 5 5 8  |   | samuel   | 1 au                   | ebarker   | _                                   |                                |   |                                     |                                    |                    |                                     | ng, MD 20901                            |  |
| -          |  |   | 23 Part1. Enter the dise s   | e, or com              | one cause on each lin   | the death.                          | Do not ente                    | r the mode of dy                                    | ng, such as care                    | diac or respiratory                | arrest,            | No.                                 | Approximate<br>Interval Between         |  |
|            | Physician  | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition PNFITMONT A |  |                        |   |                                     |                                |   |                                     |                                    |                    |                                     | Onset and Death                         |  |
| 5.         | /Medical   |   | resulting in death)  | -                      | Due to (or as   |                                     |                                |   |                                     |                                    |                    | -                                   |   |  |
| 4          | Examiner   |   | Sequentially list conditions   | - 1                    | b   |                                     |                                |   |                                     |                                    |                    |                                     |   |  |
|            | p =  | ner   | Sequentially list conditions, if any, leading to immediate cause. Enter underlying  Due to (or as a consequence of): |                        |   |                                     |                                |   |                                     |                                    |                    |                                     |   |  |
|            | rificate be executed<br>g physicien and<br>as the burial-transit   | Examiner  | Cause (Disease or injury that initiated events resulting in death) Last  | 1                      | c   |                                     |                                |   |                                     |                                    |                    |                                     |   |  |
| ŠĆ,        | cien s   |   | 1004g 002/ 2201  |                        | Due to (or as   | a conseque                          | ance or).                      |   |                                     |                                    |                    |                                     |   |  |
| 68760,     | cate t   | Aedicai   |  |                        | d   |                                     |                                |   |                                     |                                    |                    |                                     |   |  |
|            |  | /Me   | IF FEMALE:   |                        | 23c. If yes, outcome  | of pregnan                          | cv                             |   |                                     |                                    |                    | 23d. Date of d                      | elivery                                 |  |
| Box        | death cert<br>e attendin<br>d for use a  | cian  | 23b. Was decedent pregnan in the past 12 months?   |                        | 1☐Live birth<br>4☐Pregnant at                                   | 2 Fetal o                           | death 3                        | Ectopic pregnanc<br>Other (specify) _               | у                                   |                                    |                    | Month                               | Day Year                                |  |
| o.         | 0 0  | Physician/N   | 1 □ Yes 2 □ <b>X</b> No<br>9 □ Unknown   |                        | 9□ Unknown  |                                     |                                |   |                                     |                                    |                    |                                     |   |  |
| ۵.         | that<br>ned b  | by Pt   | Part II. Other significant cor   | ditions                | contributing to death b   | ut not resul                        | ting in the un                 | iderlying cause gr                                  | ven in Part I.                      | 23e. Dio                           | tobacc             | o use contribute                    | to the cause of death?                  |  |
| ds<br>ds   | w requires to been signed should be  |   |  |                        |   |                                     |                                |   |                                     | _ 10                               | ] Yes              | 2 <b>X</b> No 3 □                   | Probably 4 Unknown                      |  |
| Records,   | The law requires that the tite has been signed by the bage 2 should be detache   | Completed   |  |                        |   |                                     |                                |   |                                     | 24a. Wa                            |                    | 24b. Were                           | autopsy findings available              |  |
|            | The lay  | E   |  |                        |   |                                     |                                |   |                                     | _ pe                               | topsy<br>formed    | ? death                             |   |  |
| Vital      |  | a   | 25. Was case referred to me  | dical                  |   |                                     |                                |   | 26. Place of I                      | 1 XYes Death Check onli            |                    | NO ILI                              | es 2 XNo                                |  |
| >          | ysician;<br>s certific<br>director,  | 0   | examiner?<br>1 ☐ Yes 2 ☐ No  |                        | Hospital:   | nt 2 🗆 E                            | R/Outpatient                   | 3 DOA Ot  |                                     | gHome 5□Re                         |                    | 6 ☐Other (S <sub>i</sub>            | pecify)                                 |  |
| l of       | Attending Physician; r death. ector: After this certific by the funeral director.  | L iu  | 27. Manner of Death  |                        | 28a. Date of Inju<br>(Month, Da                                 |                                     | 28b. Time of<br>Injury         | 28c. Inju<br>Wo                                     | ry at                               |                                    |                    | njury occurred                      |   |  |
| jo         | anding lath.   | atic  |  | vestigatio             | on  |                                     | , , _ ,                        |   | Yes 2 No                            |                                    |                    |                                     |   |  |
| Division   | il or Attending<br>after death.<br>I Director: After<br>d in by the funer  | Certification;  |  | ould not b<br>termined |   | ury - At hon<br>c. <i>(Specify)</i> | ne, larm, stre                 | eet, factory, office                                |                                     | 281. Location<br>City or 1         | (Street<br>own, St | and Number or<br>ate)               | Rural Route Number,                     |  |
|            | To the Hospital or Attenwithin 24 hours after deation the Funeral Directors completely filled in by the  | edicai C  | 29a. Certifier 1 X Cer<br>(Check only 2 Med<br>one)  | tifying P              | hysician: To the best<br>miner: On the basis o<br>and manner st | f examination                       | rledge, death<br>on and/or inv | occurred at the trestigation, in my                 | me, date and pl<br>opinion, death o | ace, and due to the                | e, date a          | e(s) and manner<br>and place, and d | as stated.<br>ue to the cause(s)        |  |
|            | vithin 2<br>To the Complet   | Med   | 29b. Signature and title of ce   | ntitier                |   |                                     |                                | 29c. Licen:   | se number                           |                                    | 29d. l             | Date signed (Mo                     | nth, Day, Year)                         |  |
|            | _  |   | ) TM   |                        | 1111 -  |                                     |                                | 010   | 1235548                             | (VA)                               |                    | TULY =                              | 3.2006                                  |  |
|            | 10   |   | 30. Name and address of pe   | rson who               | completed cause of c  | leath (Item                         | 23a) (Type, I                  |   |                                     | CONAL NAV                          | 1                  |                                     |   |  |
|            |  |   | TIMOTHY M. C   |                        |   |                                     |                                |   |                                     | HESDA MD                           |                    |                                     | COLUMN TOTAL                            |  |
| 100        |  | ate   | 31. Date filed (Month, Day,  | (ear)                  | 32 Registr  | ar's Signati                        |                                | NE  |                                     |                                    | ,                  |                                     |   |  |
| 松          | Regist   | rar.  | JUL  | 05 2                   | UUG BEEN  | U B                                 | Ace.                           | HELD  |                                     |                                    |                    |                                     |   |  |

|                |   | 1              | For State   | State of Ma   | -                               |          | irtment of He                               |                          | nd Men                      |                                       | ene<br>g. No.        | 6                       | 22581  |
|----------------|---|----------------|---|---|---------------------------------|----------|---|--------------------------|-----------------------------|---------------------------------------|----------------------|-------------------------|--|
|                |   |                | Registrar  I. Decedent's Name (First, Middle, L   | ast)  |                                 |          |   | -                        | 2.0                         | 1                                     |                      | 3. Time of Death        |  |
|                | Physicia  | ın             | ARTHUR SAMUEL   | FOUCHE  |                                 |          |   |                          | '                           | Month                                 |                      | Year<br>2006            | 5:40 PM  |
|                | /Medic<br>Examin  |                | la. Facility Name (If not institution, g  |   |                                 |          | 4b. City, Town, or L                        | ocation of               | Death                       | V-5.                                  | 4c. County o         |                         |  |
|                | Examin  | ٠,             | WASHINGTON COUNT  | Y HOSPITAL  |                                 |          | Hageeston                                   | 30                       |                             |                                       | WASIN                |                         |  |
|                | . Funeral   |                |   |   | e (In yrs. last bir             |          |   | If Under 24<br>Hours     | 4 Hrs. 8. C                 | Nate of Birth<br>Month, Day,<br>Y 23, | Year)                | 9. Birthpl<br>Count     | ace (State or Foreign                          |
|                | Director  |                | 215-36-8235   | TAM ZUF   | 83                              | Yrs.     |   |                          | MA                          | Y 23,                                 | 1923                 | MARY                    | LAND   |
|                | and   | -              | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City, Tow                  | n or Lo  | cation                                      |                          |                             |                                       |                      | 10                      | d. Inside City Limits                          |
|                | Maryi   | ò              | MARYLAND WASHIN   | ICTON   |                                 |          | BO  | ONSB(                    | ORO                         |                                       |                      |                         | 1 ☐ Yes 2 🔀 No                                 |
|                | r 28a   | 2 -            | 10e. Street and Number  | 101011  |                                 |          | 10f. Zip Code                               |                          |                             | 10                                    | g. Citizen of Wi     | hat Coun                | try?   |
|                | h with  | a D            | 53 SUNRISE CIRCI  | LΕ  |                                 |          | 2   | 21713                    |                             |                                       | J                    | J.S.A                   | ١.   |
|                | deat<br>arms  | Funeral        | 11. Marital Status  | 12. Was Decedent<br>Armed Forces?                             |                                 | 13.      | Was Decedent of His<br>f Yes, specify Cuban | panic Orig<br>, Mexican, | in? (Specify<br>Puerto Rica | Yes or No-<br>n, etc.)                | 14. Race<br>Black    | - America<br>, White, e |  |
| 98             | within 72 hours after death with the Maryland<br>ene.<br>Than "natural", or Itams 23a or 28a-f show<br>Ina Medical Evarth at most be notified at                                      |                | 1 Never Married 2 Married   | If Yes, Give  | No                              |          | 1 ☐ Yes 2 🗓 No                              | Specify:                 |                             |                                       | Specify:             | TaT                     | HITE   |
| 21215-0036     | hours<br>tural  | ed by          | 3 Widowed 4 Divorced  15. Decedent's  | Year or Dates:  | 16a                             | Dece     | dent's Usual Occupat                        | ion                      |                             | 1                                     | 16b. Kind of Bus     |                         |  |
| 15             | in 72<br>"na" r   | olete          | (Specify only highest of  | irade completed)  |                                 | (Give    | kind of work done du<br>DO NOT use retired) | iring most               | of working                  |                                       |                      |                         |  |
| 212            | y with<br>jiene.<br>r thar  | Completed      | Elementary/Secondary (0-12) 12  | College (1-4or  | 5+)                             |          | MANAC                                       | GER                      |                             |                                       | F/                   | RMIN                    | īG   |
| פ              | be filed within 72 hours after death with the Marylan tal Hygiene. Id all Hygiene. Id other than "natural; or Itams 23a or 28a-f show ovent, the Medical Evant er must be notified at | Be             | 17. Father's Name (First, Middle, La  | st)   |                                 |          |   | 18. Mother               | 's Name (Fi                 | rst, Middle, N                        | flaiden Sumame       | )                       |  |
| /lar           | 2 should be<br>and Mental<br>Is markad of<br>aumatic evi  | 70             | ROY TEMPLE FOUC   | Æ   |                                 |          |   |                          | IE RUN                      |                                       |                      |                         |  |
| Maryland       | 2 sho<br>and<br>Is my   |                | 19a. Informant's Name/Relationship (Type, Print)  MELANIE S. FOUCHE/DAUGHTER  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2  1136 SUNNYSIDE DRIVE, HAGERSTOWN, MARYLu |   |                                 |          |   |                          |                             |                                       |                      |                         |  |
|                | ss 1 and 2 should<br>of Health and Men<br>itam 27 Is marka<br>r othar traumatic   |                | MELANIE S. FUUCH. 20a. Method of Disposition  | E/DAUGHIER  |                                 | _        | osition (Name of                            | 2 DKI                    | Date                        |                                       | 20c. Location - 0    |                         |  |
| Baltimore,     | ages<br>or of the   |                | 1 X Burial 2 ☐ Cremation 3  |   | cernete                         | ry, cre  | matory or other place                       | i i                      | 106 106                     |                                       |                      | •                       |  |
| Hir            | it. Partmer<br>intant<br>injury   |                | *4 □Donation 5 □ Other (Spe<br>21. Sign ture of uperal Service Lin  |   | ST. PA                          |          | S LUTH. CI                                  |                          |                             |                                       | reksvill<br>d Nation |                         | MARYLAND                                       |
| Ba             | permit. Pages 1 a Department of He Important: If itam any injury or oths  |                | May M   | Paul N  | 1. Dean                         | В        | AST FUNERA                                  | AL HO                    | MIH.                        |                                       | ro, Mary             |                         |  |
|                |   |                | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List or  | omplications that cause                                       | d the death. Do                 | not en   | ter the mode of dying                       | , such as c              |                             |                                       |                      |                         | Approximate<br>Interval Between                |
|                | Physician   |                | Immediate Cause (Final disease or condition   | n   | toin                            | FA       | LURI  |                          |                             |                                       |                      |                         | Onset and Death                                |
|                | /Medical  |                | resulting in death)   | _ a   | s a consequence                 |          | 1   |                          |                             |                                       |                      |                         | ~ 1  |
|                | Examiner  |                | Sequentially list conditions,   | 6. Multip   | Multiple RIS TEACTURES          |          |   |                          |                             |                                       |                      |                         | 1 days   |
|                | pe tis  | Iner           | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  MATCL  Cellis   |   |                                 |          |   |                          |                             |                                       |                      | 7 1.                    |  |
|                | and and   | Examine        | that initiated events resulting in death) Last  | c. Due to (or a   | s a consequence                 | of):     | Collision                                   |                          |                             |                                       |                      |                         | 12495  |
| 8760,          | The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the burial-transit                     | a<br>E         |   |   |                                 |          |   |                          |                             |                                       |                      |                         |  |
| 687            | ficate<br>p physics the   | edical         |   | d   |                                 |          |   |                          |                             |                                       |                      |                         |  |
| Вох            | eath certific<br>attending p  | N/M            | 1F FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcom   | e of pregnancy<br>2  Fetal deat | h 31     | □Ectopic pregnancy                          |                          |                             |                                       | 23d. Date            |                         | -  |
|                | death   | sicla          | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  |   | at time of death                |          | Other (specify)                             |                          |                             |                                       | Mon                  | th                      | Day Year                                       |
| P.0            | at the de<br>by the a   | Physician/M    | 9 Unknown   |   |                                 |          | . ( ) ( )                                   | - I- Deat                |                             | 120 Did tob                           | nana usa anata       | huto to th              | ne cause of death?                             |
|                | ires tha<br>signed I  | by             | Part II. Dther significant condition  | s contributing to death                                       | but not resulting               | in the i | inderlying cause give                       | n in Part I.             |                             |                                       |                      | 3 ☐ Prob                | **   |
| orc            | w requir  | eted           | faostorie Co  | NCEC.   |                                 |          |   |                          |                             |                                       |                      |                         |  |
| Vital Records, | e law<br>has b  | Completed      | Hyperins  |   |                                 |          |   |                          |                             | 24a. Was a<br>autops<br>perform       | ned? p               | rior to cor<br>eath?    | psy findings available<br>npletion of cause of |
| a              |   |                | 25. Was case referred to medical  |   |                                 |          |   | 26 Place                 | of Dooth (C                 | 1 ☐ Yes 2<br>heck only on             | <b>X</b>             | ☐ Yes                   | 2□ No  |
| Σ              |   | o Be           | examiner?  Yes 2 No   | Hospital:   | tient 2 TER/C                   | utpatie  | nt 3 DOA Othe                               |                          |                             |                                       | ence 6 🗆 Othe        | r (Specifi              | y)   |
| of             | g Phys<br>er this<br>eral di  | <b> </b>       | 27. Manner of Death   | 28a. Date of In<br>(Month, D                                  | iurv 28b.                       | Time     |   | at                       |                             |                                       | ow injury occurre    |                         |  |
| lon            | Attending<br>r death.<br>actor: After<br>by the funer   | atlo           | 1 □Natural 5 □ Pending  2€ Accident investiga   | tion Jun 2  | Ziock                           | 122      |   | -                        | 40 N                        | later U                               | thiele (             | allis                   | 10-  |
| Division       | or Atterde  | Certification; | 3 Suicide 6 Could no<br>4 Homicide determin   | ed 28e. Place of I  | etc. (Specify)                  |          | treet, factory, office                      |                          | 28f.                        | City or Town                          | n, State)            |                         | A Route Number,                                |
|                | urs aff   | Cer            |   |   | MAR RO                          |          |   |                          | 4 -1                        |                                       | EUZCLE               |                         | 1110   |
|                | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To tha Funeral Diractor: After th<br>completely filled in by the funeral   | Medical        | 29a. Certifier 1 Certifying (Check only 2 Medical E   | Physician: To the bes<br>xaminer: On the basis<br>and manner: | of examination a                | and/or i | nvestigation, in my op                      | inion, deal              | th occurred a               | at the time, d                        | ate and place, a     | nd due to               | the cause(s)                                   |
|                | o the<br>vithin<br>o tha  | Me             | 29b. Signature and title of certifier   |   |                                 |          | 29c. License                                | number                   |                             | 2                                     | 9d. Date signed      | (Month,                 | Day, Year)                                     |
|                | - 5 - Ö   |                | DAD ma  | O ONE   |                                 |          | 000   | 5691                     | 55                          |                                       | July                 | 3                       | 2006   |
|                |   |                | 30. Name and address of person w  | no completed cause of   | death (Item 23a                 | ) (Туре  | , Print)                                    |                          | , 1                         | ,                                     | 70.0                 |                         | =/.0   |
| Sh             | 1-10  |                | Steplan Katil   | 251 E   | . Antict                        | am       | Stroat                                      | <i>F</i>                 | 10918                       | teun                                  | 1110                 | 21                      | 140  |
|                | St<br>Regist  | ate<br>trar    | 31. Date filed (Month, Day, Year)  JUL 0 6  | 2006  | strar's Signature               | fo       | 29c. License<br>DOO.<br>Print)<br>Street    |                          |                             |                                       |                      |                         |  |

|                 |                 | For  |                              |                                 | nd / Depa          | artment of h   | lealth ar                     |                               | _                            | _           | nbie.                      | 225                          | 82             |
|-----------------|-----------------|--|------------------------------|---------------------------------|--------------------|--|-------------------------------|-------------------------------|------------------------------|-------------|----------------------------|------------------------------|----------------|
|                 |                 | - State<br>Registrar   |                              |                                 | Ce                 | rtificate of   | Death                         |                               | Reg.                         | No.         | UU                         |                              |                |
|                 |                 | 1. Decedent's Name (First, Middle, L   | .ast)                        |                                 |                    |  |                               |                               | te of Death<br>onth          | Day         | Year                       | 3. Time of                   | Death          |
| ysicia<br>1edic | _               | Ildra Mahala   | a Fra                        | ntz                             |                    |  |                               | Ju                            | .1y                          | 8           | 2006                       | 6:45                         | A <sup>M</sup> |
| amin            |                 | 4a. Facility Name (If not institution, g   | ive street and nu            | ımber)                          |                    | 4b. City, Town, o  | or Location of                | Death                         |                              | 4c. Coun    | ty of Death                |                              |                |
|                 |                 | Cedar Hill Ass:  | isted Li                     | ving Fa                         | cility             | Bittir   | nger                          |                               |                              | Gar         | rett                       |                              |                |
| al              |                 |  | Sex                          | 7. Age (In yrs.                 |                    | If Under 1 Year<br>Months Days                               |                               | 4 Hrs. 8. Dat<br>Min. (Mo     | te of Birth<br>onth, Day, Ye | ar)         | 9. Birth                   | place (State of<br>intry)    | r Foreign      |
| ı               |                 | 215-16-4835  | 1□M 21∏F                     | 91                              | Yrs.               | North Bays   | 1,0010                        |                               | ch 2,                        |             | Mar                        | yĺand                        |                |
| 1               |                 | Usual Residence of Decedent  |                              | 140-0                           | (h. T              |  |                               |                               |                              |             |                            | 10d. Inside Cit              | n. Limita      |
|                 |                 | 10a. State 10b. County   |                              | 10c. C                          | ity, Town or Lo    | ocation  |                               |                               |                              |             |                            |                              | •              |
| l               | cto             | MD Garret  | t                            | S                               | wanton             |  |                               |                               |                              |             |                            | 1 Tyes                       | X              |
|                 | Director        | 10e. Street and Number   |                              |                                 |                    | 10f. Zip Code  |                               |                               | 10g.                         | Citizen of  | f What Cou                 | ntry?                        |                |
|                 | ie l            | 3464 Swanton Ro  | ad                           |                                 |                    | 21561  |                               |                               |                              |             | d Sta                      |                              |                |
|                 | Funerai         | 11. Marital Status   | 12. Was Dec                  | cedent Ever in to               | J.S. 13.           | Was Decedent of his Yes, specify Cub                         | Hispanic Originan, Mexican, I | in? (Specify Ye Puerto Rican, | etc.)                        |             | ace - Ameri<br>ack, White, |                              |                |
|                 |                 | 1 Never Married 2 Married  | 1 ☐ Yes<br>If Yes, G         | X No<br>ive                     |                    | 1 ☐ Yes 2 ☒ No   |                               |                               |                              | Spec        | ifv:                       |                              |                |
|                 | a b             | 3 Widowed 4 □ Divorced   | Year or I                    | Dates:                          |                    | - 1  |                               |                               |                              |             | Wh                         | ite                          |                |
|                 | Completed       | 15. Decedent's<br>(Specify only highest)   | Education<br>grade completed | )                               | 16a. Dece<br>(Give | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | pation<br>during most o       | of working                    | 16                           | o. Kind of  | Business/In                | ndustry                      |                |
|                 | idu             | Elementary/Secondary (0-12)  |                              | (1-4or 5+)                      |                    |  | a)                            | -                             |                              | _           |                            | _                            |                |
| f               | Ö               | 8  |                              |                                 | Cler               | k  | 1                             |                               | 1112                         |             | il Sa                      | les                          |                |
|                 | De              | 17. Father's Name (First, Middle, La   | st)                          |                                 |                    |  |                               | 's Name (First,               |                              |             |                            |                              |                |
| 1               | 0               | Josiah G. F  | riend                        |                                 | _                  | _  | Mary                          | y J.                          | Swei                         | ltzer       |                            |                              |                |
| •               |                 | 19a. Informant's Name/Relationship   | (Type, Print)                |                                 | 19b. Maili         | ng Address (Street   | and Number                    | or Rural Route                | e Number, C                  | ity or Tow  | n, State, Zij              | p Code)                      |                |
|                 |                 | Audrey Friend,   | Nephew                       |                                 | 27 P               | ine Hollo  | ow Rd.,                       | , Swant                       | on, MI                       | 21          | 561                        |                              |                |
|                 |                 | 20a. Method of Disposition   |                              |                                 | Place of Dispo     | osition (Name of<br>matory or other pla                      | ice)                          | Date                          | 200                          | c. Location | n - City or T              | own, State                   |                |
|                 |                 | 1 🖾 Burial 2 ☐ Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spe                          |                              | State   Ge                      |                    | emetery  |                               | /10/06                        | ۶                            | Swant       | on, M                      | D                            |                |
|                 | - 0             | 21. Signature of Funeral Service Lic   |                              |                                 |                    | 2. Name and Addre  |                               |                               | -                            |             |                            |                              |                |
|                 |                 | Karreren   | U 40                         | _                               |                    |  |                               |                               |                              |             |                            | land, l                      | MD             |
|                 |                 | 23a. Part1. Enter the disease, or co   |                              |                                 | ath. Do not en     | ter the mode of dvi  | ng such as ca                 |                               |                              |             | , oak                      | Approximate                  | 9              |
|                 |                 | shock, or heart failure. List or   | ly one cause in              | each line.                      | 55 1151 5          |  |                               |                               | , -, -,                      |             |                            | Interval Bety<br>Onset and D | Death          |
|                 |                 | Immediate Cause (Final disease or condition resulting in death)                    | _aC                          | -VA                             |                    |  |                               |                               |                              |             |                            | 2 N                          | 10             |
|                 |                 | leading in death)  | Due to                       | o (or as a conse                | quence of):        |  |                               |                               |                              |             |                            |                              |                |
|                 |                 | Sequentially list conditions,  | b                            |                                 |                    |  |                               |                               |                              |             |                            |                              |                |
|                 | ine             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to                       | o (or as a conse                | equence or):       |  |                               |                               |                              |             |                            |                              |                |
| Į               | Examiner        | Cause (Disease or injury that initiated events resulting in death) Last            | c                            | /                               |                    |  |                               |                               |                              |             |                            |                              |                |
| ĺ               | al E            | rossing in county and  | D09 10                       | o (or as a conse                | iquanca or).       |  |                               |                               |                              |             |                            |                              |                |
|                 |                 |  | d.                           |                                 |                    |  |                               |                               |                              |             |                            |                              |                |
| ĺ               | Mec             | IF FEMALE:   |                              |                                 |                    |  |                               |                               |                              |             |                            | -                            |                |
|                 | an/             | 23b. Was decedent pregnant   |                              | utcome of pregr<br>birth 2 ☐ Fe | tal death 3        | ⊒Ectopic pregnanc  | ;y                            |                               |                              |             | Date of deliv<br>Month     |                              | ear ear        |
|                 | Physician/Medic | in the past 12 months?<br>1 ☐ Yes 2 DENo   | 4□Preg<br>9□ Unk             | gnant at time of<br>nown        | death 5            | Other (specify)  |                               |                               |                              | 1 "         |                            | =-/                          |                |
|                 | Phy             | 9 Unknown  |                              |                                 |                    | and the second   | and the Post of               |                               | 2n Did tob-                  | 00.00= 65   | entaile                    | the course of d              | ooth?          |
|                 | þ               | Part II. Other significant condition   | s contributing to            | death but not re                | souiting in the t  | maenying cause gr  | ven in Paπ I.                 | 2.                            |                              |             |                            | the cause of d               |                |
|                 |                 |  |                              |                                 |                    |  |                               |                               | 1 ∐ Yes                      | 2 □ No      | 3 ☐ Pro                    | loadiy 4                     | Inknown        |
|                 | Completed       |  |                              |                                 |                    |  |                               | 24                            | 4a. Was an<br>autopsy        | 245         | . Were aut                 | opsy findings                | available      |
|                 | Eo              |  |                              |                                 |                    |  |                               | 41                            | performe<br>☐ Yes 🌫          |             | death?                     |                              |                |
| l               |                 | 25. Was case referred to medical   |                              |                                 | 100 101            |  | 26. Place                     | of Death (Che                 |                              | -           |                            |                              |                |
| Ì               | o Be            | examiner?<br>1 ☐ Yes 2   | Hospital: 1                  | Inpatient 2                     | ☐ ER/Outpatie      | nt 3 DOA Ot  | hoc                           | sing Home 5                   |                              | e 6 🗆       | ther (Speci                | ify)                         |                |
|                 | Η.              | 27. Manner of Death  | 28a. Dat                     | e of Injury                     | 28b. Time o        |  |                               |                               | escribe how                  |             |                            | ,,                           |                |
| l               | Certification:  | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investiga                                    |                              | onth, Day Year)                 | Injury             |  | ork?<br>]Yes 2.∐N             | 40                            |                              |             |                            |                              |                |
|                 | fica            | 3 Suicide 6 Could no   | t be 28e. Pla                | ce of Injury - At               | home, farm, si     | reet, lactory, office  |                               | 28I. Lo                       | cation (Stree                | et and Nur  | nber or Rur                | ral Route Num                | ber,           |
|                 | erti            | 4 Homicide determin  | buil                         | ding, etc. (Spec                | cify)              | , , ,  |                               | Ci                            | ity or Town, S               | state)      |                            |                              |                |
|                 |                 | 29a. Certifier Certifying  | Physician: To the            | he best of my ki                | nowledge dea       | th occurred at the t   | me, date and                  | place, and du                 | e to the caus                | se(s) and   | manner as                  | stated.                      |                |
|                 | Medical         |  | xaminer: On the              |                                 |                    | nvestigation, in my  |                               |                               |                              |             |                            |                              | )              |
|                 | Mec             | 29b. Signature and title of certifier  | and me                       | states.                         |                    | 29c. Licen   | se number                     |                               | 29d                          | . Date sign | ned (Month.                | . Day, Year)                 |                |
|                 |                 |  |                              | ~                               |                    | 4-   | 2015                          | TU                            |                              | _           | 117                        | 10                           | 1              |
|                 |                 | , 00   |                              |                                 | _                  | - 17   | د ا ما                        |                               |                              | 1           | 110                        |                              | 0              |
|                 |                 | 30. Name and address of person w   | ho completed ca              | use of death (Ite               | өт 23а) (Туре      | , Print)   |                               | 0                             | 11                           | Q.          | 1 4 4 1                    | 7/                           | 1-,-           |
|                 |                 | AD WILL  | 10                           | 69                              | WO                 | 1011   | Tre)                          | 00                            | KICKY                        | (U)         | VVI                        | 1                            | <i>ار</i> د    |
|                 | ite             | 31. Date filed (Month, Day, Year)  JUL 1   | 0 2006                       | Registrar's Sig                 | nature<br>a.       | A  |                               |                               |                              | C           | ,                          |                              |                |
|                 | rar             | JOF T  | 0 2000                       | MARIO 10-                       | All y              | Bronth D   |                               | 57.00                         |                              |             |                            |                              |                |
| /2              | 001             |  |                              |                                 |                    | 1  |                               |                               |                              |             |                            |                              |                |

ORIGINAL

|                            |  |                     | 1 - For<br>State<br>Registrar   |  | arylar      |                          | artment of H<br>tificate of I   |                                       | and M                    | R   | leg. No.                          | 06                                    | 22583   | 3 |  |
|----------------------------|--|---------------------|---|--|-------------|--------------------------|---|---------------------------------------|--------------------------|---|-----------------------------------|---------------------------------------|---|---|--|
| ı                          | Physici  | an                  | 1. Decedent's Name (First, Middle, Last<br>Lorraine Lynn  |  |             |                          |   |                                       |                          | 2. Date of Dea<br>Month                   | Day                               | Year                                  | 3. Time of Death                              |   |  |
|                            | /Medic<br>Examin   |                     | 4a. Facility Name (If not institution, give   |  |             |                          | 4b. City, Town, or  | Location o                            | of Death                 | July                                      | 多 ユ<br>4c. County                 | of Death                              | 16:44 M                                       | _ |  |
|                            | Lxaiiiii   | CI                  | WMH5- BRad  | dock C   | AMO         | 145                      | Cume  | BER                                   | LA                       | nD  | ALL                               | EB                                    | ANY   |   |  |
|                            | Funeral<br>Director  |                     | 5. Social Security Number 6. Se 215–26–7103   |  | e (in yrs.  | last birthday)<br>Yrs.   | If Under 1 Year<br>Months Days  | If Under 2<br>Hours                   |                          | 8. Date of Birth<br>(Month, Day<br>July 3 | 1 1931                            | Cou                                   | place (State or Foreign<br>ntry)<br>7 Land    |   |  |
|                            | Maryland   | tor                 | Usual Residence of Decedent  10a. State 10b. County  MD. Allegany   | 7  |             | y, Town or Lo<br>Vestern |   |                                       |                          |   |                                   | 10d. Inside City Limits 1XXYes 2 □ No |   |   |  |
|                            | 3a or 28e  | Funeral Director    | 10e. Street and Number 420 Hammond S  | St.  | L           |                          | 10f. Zip Code<br>2156   | 52                                    |                          |   | Og. Citizen of V                  |                                       | •   | - |  |
| 036                        | permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: if item 27 is marked other then "naturel', or Iteme 23e or 28e-f ehow striply or other traumatic event, the Medical Evantian must be notified at ance. | ğ                   | 11. Marital Status  1 Never Married 2 Married  3 XXVidowed 4 Divorced   | 12. Was Decedent<br>Armed Forces'<br>1  Yes 2 If<br>If Yes, Give<br>Year or Dates: | ?           | '                        | Was Decedent of Hi<br>f Yes, specify Cuba<br>I ☐ Yes 27210                    | spanic Orig<br>n, Mexican<br>Specify: | gin? (Spe<br>, Puerto I  | ecify Yes or No-<br>Rican, etc.)          |                                   | e - Ameri<br>ck, White,<br>whi        |   |   |  |
| 21215-0036                 | id within 72 ho<br>giene.<br>er then "natu   | Completed           | 15. Decedent's Edi<br>(Specify only highest grad<br>Elementary/Secondary (0-12)<br>12   | cation<br>le <i>completed)</i><br>College (1-4or                                   | 5+)         | (Give                    | dent's Usual Occupi<br>kind of work done o<br>DO NOT use retired<br>Comemaker | turing most                           | of workii                | 16b. Kind of Business/Industry  Housework |                                   |                                       |   |   |  |
| altimore, Maryland         | ould be file<br>Mental Hy<br>arked oth   | To Be (             | 17. Father's Name (First, Middle, Last) Samuel  | Bradley  |             |                          |   | 18. Mother                            | _                        | (First, Middle,<br>Bernard                | Maiden Suman                      | 7 <b>e</b> )                          |   |   |  |
| Mar                        | 12 sh<br>h and<br>7 is m<br>traum  |                     | 19a. Informant's Name/Relationship (T) Rhonda Mou/ daugh  |  |             |                          | ng Address (Street a  |                                       |                          |   |                                   |                                       |   |   |  |
| <u>ق</u>                   | is 1 and 2<br>of Heelth a<br>item 27 is  |                     | 20a. Method of Disposition  | icer   | 20b. F      |                          | Box 1990<br>sition (Name of<br>natory or other place                          | •                                     | D                        | West                                      | 20c. Location                     |                                       | 36757<br>own, State                           | _ |  |
| E                          | Pages<br>nent of<br>int: if i  |                     | 12⊠Burial 2 ☐ Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify,   |  | Ph          | ilos C                   | enetery   | θ)                                    | 07/1<br>2006             | 2/  | Western                           | port                                  | , Maryland                                    |   |  |
| Balt                       | permit. Departnimports eny injt.   |                     | 21. Signature of Funeral Service Licens   | e Ba   | l           |                          | . Name and Addres   |                                       | y Bo                     | al Fune                                   |                                   |                                       | 21562   |   |  |
|                            | Physician<br>/Medical  |                     | 211 Church St., Westernport, Maryland 215  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval B Onset and disease or condition resulting in death)  215 Approximation and the death of the mode of dying, such as cardiac or respiratory arrest, Interval B Onset and disease or condition resulting in death)  216 Approximation and the death of the mode of dying, such as cardiac or respiratory arrest, Interval B Onset and disease or condition resulting in death) |  |             |                          |   |                                       |                          |   |                                   |                                       |   |   |  |
|                            | Examiner   | Examiner            | Sequentially list conditions by Acate Myocarlial infarction   |  |             |                          |   |                                       |                          |   |                                   | 1day<br>10 years                      | _   |   |  |
| ). Box 68760,              | death certifi<br>e attending I<br>id for use es  | Physician/Medical E |   |  |             |                          |   |                                       |                          |   |                                   | te of deliv                           | ery<br>Day Year                               | _ |  |
| ds, P.O.                   | 9 G 9  | þ                   | 9 ☐ Unknown  Part II. Other significant conditions co   | 9□ Unknown<br>ntributing to death t  | out not res | sulting in the ur        | nderlying cause give  | en in Part I.                         |                          |   | bacco use cont                    |                                       | he cause of death?                            | - |  |
| Division of Vital Records, | o = o  | Completed           |   |  |             |                          |   |                                       |                          | 24a. Was a autops                         | in 24b.                           | Were auto<br>prior to co<br>death?    | opsy findings available impletion of cause of | _ |  |
| ital                       | ician: Th<br>certificate<br>rector, pag  | BeC                 | 25. Was case referred to medical examiner?  |  |             |                          |   | 26. Place                             | of Death                 | 1 ☐ Yes<br>(Check only or                 | 7                                 | I □ Yes                               | 2□ No   | - |  |
| ) <                        | Physician:<br>this certificanal director,  | ဥ                   | 1 □ Yes 2 No  | Hospital: 12 Inpati  |             | ER/Outpatien             |   | 4 🗆 Nui                               | rsing Hon                | ne 5□Reside                               | ence 6 □Oth                       | er (Specii                            | <b>5</b> /)                                   | _ |  |
| sion (                     | After<br>Nune  | Certification:      | 27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be  | 28a. Date of Inju  | y Year)     | 28b. Time of<br>Injury   | M 1 □   | rat<br>⟨?<br>Yes 2 □ N                | No                       | 28d. Describe h                           |                                   |                                       |   |   |  |
| Div                        | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the   |                     | 4 Homicide determined   | building, e  | tc. (Specii | <b>(y</b> )              | eet, factory, office  |                                       |                          | City or Town                              | n, State)                         |                                       | al Route Number,                              |   |  |
|                            | • Hos<br>24 hc<br>• Fun<br>letely  | edicai              | 29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam   | iner: On the basis of<br>and manner si   | of examina  | ition and/or inv         | restigation, in my or   | ie, date and<br>pinion, deat          | d place, a<br>th occurre | and due to the c<br>ed at the time, d     | ause(s) and ma<br>late and place, | inner as s<br>and due t               | stated.<br>the cause(s)                       |   |  |
|                            | To the within 2 To the complet   | Me                  | 29b. Signature and title of conflier  | 16)  | 12          |                          | 29c. License  |                                       |                          |   | 9d. Date signe                    | -                                     |   | _ |  |
|                            |  |                     | 1 Clark   | Cel  | Cy!         | w                        | 100   | 214                                   | 188                      |   | July                              | 8                                     | 2006  |   |  |
|                            | 8  |                     | 30. Name and address of person who comes  | T. Devi  | in 1        | m 23a) (Type,            | Print) Pous 1   | las A                                 | lve                      | Long                                      | coning                            | ,,                                    | 41.   |   |  |
|                            | Sta<br>Registr   |                     | 31. Date filed (Month, Day, Year)   | 32. Regist   | rar's Signa | ature                    | Acres 1   |                                       |                          |   |                                   |                                       |   |   |  |

State of Maryland / Department of Health and Mental Hygiene-For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 06 **Physician** 20 2243 Margaret K. Ford 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X P Yrs. Director 218-80-2682 83 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ent: If item 27 le marked other then "neturel", or Items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23e or 28a-f show ther must be notified at 1 Yes 2 No Completed by Funeral Director MD Calvert Dunkirk 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20754 U.S.A. 4280 Ferry Landing Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 8 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gertrude Ford McKinley Wilson item 27 le marke other treumatic ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6707 Wilburn Drive Capitol Heights, MD 20743 Calvert Ford/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Importent: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/07/06 Dunkirk, MD 4 Donation 5 Other (Specify) Cooper's UM Church Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facili Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwo Onset and De Immediate Cause (Final **Physician** SCIASIS disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner bowel obstruct ion due & Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequer Physician/Medical Examiner sician and burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed ad hasion Due to (or as a consequence of) physician s the burial Box 68760, IF FEMALE: esn If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month 4 Pregnant at time of death 5 Other (specify) ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 Ho 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2∏ No 1 Yes 21 N 1 TYes director 25. Was case referred to medical 26. Place of Death (Check only one, examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 1 Inpatient 277 H 2 ER/Outpatient 3□ DOA 27. Manner of Death Date of Injury (Month, Day Year, 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Hatural Injury 5 Pending death. investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours aft Eunerel Di letely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mai 23a) (Type, Print) 30. Name and address of person ause of death (Item d 31. Date filed (Month, Day, Year) 32. Registra State JUL 2006 Registrar

DHMH 17 Rev 1/2001

Registrar

JUL 1 3 2006

06-04822 Daniel Frank

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Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 2006 22586 Certificate of Death Reg No Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month D July 7, 2006 Daniel Andrew Frank 1419 hrs **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silver Spring 3205 Kilkenny Street 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min May 23, 1984 Maryland 22 Director 214-08-5762  $_{1}X_{M}$ Usual Residence of Decedent Oc. City, Town or Location 10d. Inside City Limits 10a. State Silver Spring 1 Yes 2 XNo Maryland Montgomery 23a or 28a-f show notified at once. nours after death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number United States 20904 3205 Kilkenny Street 14 Race - American Indian, Black Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 11 Marital Status or items 2 must be r Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 0r White Yes 2 X No specify If Yes. Give Year Specify Widowed 4 Divorced à Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12 College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hopartment of Health and Mental Hygiene College marked other than 'c event, the Medical Student 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nancy Janios F. Michael Frank Be traumatic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 3205 Kilkenny Street Silver Spring, Maryland 20904 If item 27 is F. Michael Frank -father Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a Method of Disposition Gate of Heaven Cemetery 7/14/2006 Silver Spring, Maryland 1 X Burial 2 Cremation 3 Removal from State mportant: Donation 5 Other Specify Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Ma 21 Signature of Funeral Service Lie en Maryland 2070 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Narcotic (Morphine) intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter U senying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical attending physician for use as the burial -X UNPENDED AMENDED item#23a,27,28a-f,perME,g857,7/31/06 TT certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IÉ FEMALE 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown a Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I P.O. ş Yes 2 No 3 Probably 4 Unknown Completed Records, 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed ✓ Yes 2 1 🗸 Yes 26 Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medica Be Division of Vital Other<sub>4</sub> examiner? ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ✓ Yes ဥ 28b. Time of Injury 28d. Describe how injury occurred Manner of Death 28a Date of Injury (Month, Day, Year 28c. Injury at Work? Certification: Natural 1 Yes 2 y No Pending Fnd 7/7/2006 Fnd 2:10 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City or Town, State) 3205 Kilkenny Street Silver Spring, MD 3 6 X Could not be Suicide determined Found: residence Silver Spring, Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner, stated 29c. License numbe 29d Date signed (Month, Day, Year) 29b. Signature and title of July 8, 2006 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State

Registra

Susan Hogan MD.

Day, Year)

2006 4

111 Penn Street, Baltimore, MD 21201

Assistant/Medical Examiner

32 Registrar's Signatur

100

|                            |  |                | _ For   | State of Marylan  | d / Depa                        | artme                   | nt of H                      | lealth and                             | •                                    |                             | •                                 | •   |             |
|----------------------------|--|----------------|---|---|---------------------------------|-------------------------|------------------------------|--|--------------------------------------|-----------------------------|-----------------------------------|---|-------------|
|                            |  |                | 1 - State<br>Registrar  |   | Ce                              | rtifica                 | ite of L                     | Death                                  |                                      | Reg. No                     | 200                               | 6 22                                      | 2587        |
|                            | Physicia<br>/Medic   |                | Decedent's Name (First, Middle, Last)     KENNETH FRANCIS F   | RANGIONI  |                                 |                         |                              |  | 2. Date of Month                     | Da                          | y 200                             | 1 7.2                                     | of Death    |
|                            | Examin   |                | 4a. Eacility Name (If not institution, give s   | 0 (1) 11  |                                 | 4b. Cit                 | y, Town, or                  | Location of Dea                        | ath C                                | 40                          | . County of De                    | ath                                       |             |
|                            |  |                |   | e of Buth   |                                 | 1-                      | sul.                         | timor                                  |                                      | 4                           | BALTIMO                           | RE  |             |
|                            | Funeral<br>Director  |                | 3/9-10-0902   | 7. Age (In yrs.   | last birthday)<br>Yrs.          | Month:                  | er 1 Year<br>s Days          | If Under 24 Hr<br>Hours Mir            |                                      | Day, Year,                  | )                                 | irthplace (State<br>Country)<br>SHINGTON, |             |
|                            | and  |                | Usuat Residence of Decedent  10a. State 10b. County   | 10c. Cit  | y, Town or Lo                   | ocation                 |                              |  |                                      |                             |                                   | 10d. Inside                               | City Limits |
|                            | Manyl<br>f eho   | ō              | SC ORRY   |   | EAS                             | ST COI                  | VWAY                         |  |                                      |                             |                                   |   | es 2⊠No     |
|                            | the 1  | Director       | 10e. Street and Number  |   |                                 |                         | ip Code                      |  |                                      | 10g. Ci                     | tizen of What (                   | Country?                                  |             |
|                            | With<br>3a or  |                | 107 ERSKINE DRIVE   |   |                                 |                         |                              | •                                      |                                      |                             |                                   | ,   |             |
|                            | ms 2   | era            |   | 12. Was Decedent Ever in U  | .S. 13.                         | Was Dec                 | 29526<br>edent of Hi         | spanic Origin? (<br>n, Mexican, Pue    | Specify Yes or                       |                             | U.S.A.<br>14. Race - An           | nerican Indian,                           |             |
| 36                         | d within 72 hours after deeth with the Maryland jiene.<br>r than "natural", or items 23a or 28a-1 ehow   | by Funerai     | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced  | Armed Forces?<br>1 ☑ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates: WWII              |                                 | _                       | ecify Cuba<br>2              | n, Mexican, Pue<br>Specify:            | orto Rican, etc.)                    |                             | Black, Wh<br>Specify: W           |   |             |
| 우                          | tura<br>sal E  | ed             | 15. Decedent's Educ   | cation  | 16a. Dece                       | dent's Us               | ual Occupa                   | ation                                  |                                      | 16b. k                      | (ind of Busines                   | s/Industry                                |             |
| 15                         | nin 72   | piet           | (Specify only highest grade<br>Elementary/Secondary (0-12)  | completed)  | (Give                           | kind of v               |                              | furing most of w                       | orking                               |                             |                                   | a   |             |
| 212                        | 7 2 4 2  | Completed      | 12  | College (1-4or 5+)  | I.                              | MANAGI                  | ER                           |  |                                      | F                           | OODSTORE                          |   |             |
| פ                          | be filed<br>ital Hygid<br>of other<br>event, I   | Be C           | 17. Father's Name (First, Middle, Last)   |   |                                 |                         |                              | 18. Mother's Na                        | ame (First, Mid                      | dle, Maidei                 | n Sumame)                         |   |             |
| <u>a</u>                   | Aental<br>Aental<br>rked c   | To E           | ANDREA FRANGIONI  |   |                                 |                         |                              | VINCEN                                 | NZA VALLA                            | RIO                         |                                   |   |             |
| Maryland 21215-0036        | s 1 and 2 should<br>f Health and Men<br>Itam 27 le marke<br>other traumatic  | _              | 19a. Informant's Name/Relationship (Ty)   | oe, Print)  | 19b. Mailir                     | ng Addre                | ss (Street a                 | and Number or F                        | Rural Route Nu                       | mber, City                  | or Town, State,                   | Zip Code)                                 |             |
|                            | and 2<br>balth a<br>27 le  |                | HENRY A. FRANGIONI/   | SON   | 12714                           | 4 LIM                   | E KILN                       | ROAD, HIC                              | GHLAND, M                            | ARYLAN                      | D 20777                           |   |             |
| Se                         | of Hea<br>of Hea<br>of Hea<br>of Hea<br>of Hea   |                | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R   |   | lace of Dispo<br>emetery, crei  | matory or               | other place                  | <b>9</b> )                             | Date                                 | 20c. L                      | ocation - City o                  | r Town, State                             |             |
| Baltimore,                 | nit. Pages<br>pertment of horizont: If Its   |                | 4 Donation 5 Nother (Specify)   | ENTOMBMENT CE   | RT LÍNCO<br>METERY N            | OLN<br>MAUSOI           | LEUM                         |  | E 23, 200                            | 6 BREI                      | NTWOOD. N                         | 1ARYLAND                                  |             |
| att                        | F 2 2 2 3  |                | 21. Signature of Funera Salve Lio nse   |   |                                 |                         |                              |  | HINES-RIN                            |                             |                                   |   |             |
| <u> </u>                   | Den<br>Imp   |                | Towner 1  | sellan .  |                                 | 11800                   | NEW HA                       | MPSHIRE A                              |                                      |                             |                                   |   | 20904       |
| 1                          | Physician  |                | 23a Part1. Enter the disease, or compli-<br>shock or heart failure. List only on<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | E cause on each line.   |                                 |                         |                              | 1                                      |                                      | y arrest,                   |                                   | Approxim<br>Interval B<br>Onset and       | etween      |
|                            | /Medical<br>Examiner   |                | 1   | Due to (or as a conece  | wence of):                      | Pr                      | 1550                         | 150                                    | 7                                    |                             |                                   | 22  | 1           |
|                            |  | -              | Sequentially list conditions, if any, leading to immediate  | Due to (or as a conseq  |                                 |                         |                              |  |                                      |                             |                                   | Loya                                      | cars        |
|                            | nsit   | Examiner       | Cause (Disease or injury  |   |                                 |                         |                              |  |                                      |                             |                                   | - 0.                                      |             |
|                            | te be executed<br>ysician and<br>ie burial-transit   | xar            | that initiated events cresulting in death) Last   | Due to (or as a conseq  | uence of):                      |                         |                              |  |                                      |                             |                                   |   |             |
| 760,                       | e be (   | cai            |   |   |                                 |                         |                              |  |                                      |                             |                                   |   |             |
| 687                        | ficate<br>phy.   | edic           |   |   |                                 |                         |                              |  |                                      |                             |                                   |   |             |
| Box (                      | death certificate be attending physion for use as the b  | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant   | 3c. If yes, outcome of pregna   |                                 |                         |                              |  |                                      |                             | 23d. Date of de                   | elivery                                   |             |
|                            | death<br>e atte<br>d for   | icia           | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 1 Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of d                                  |                                 | ∐Ectopic<br>] Other (:  | pregnancy<br>specify)        |  |                                      | .                           | Month                             | Day                                       | Year        |
| P.O.                       | that the dead by the detached  | hys            | 9 Unknown   | 9□ Unknown  |                                 |                         |                              |  |                                      |                             |                                   |   |             |
|                            | requires that the<br>een signed by th<br>hould be detache  | by P           | Part II. Other significant conditions con   | tributing to death but not res  | ulting in the u                 | nderlying               | cause give                   | on in Part I.                          | 23e. D                               | d tobacco                   | use contribute                    | to the cause of                           | f death?    |
| ĕ                          | w requires to been signer should be controlled to be cont |                |   |   |                                 |                         |                              |  | 1                                    | ☐ Yes 2                     | ONO 3□F                           | robably 4                                 | _Unknown    |
| 8                          | s bee  | Completed      |   |   |                                 |                         |                              |  | 24a. W                               | asan                        | 24b. Were a                       | utopsy finding                            | s available |
| Be                         | The law rate has be  | E              |   |   |                                 |                         |                              |  | pe                                   | itopsy<br>priormed?         | prior to<br>death?                | completion of                             | cause of    |
| <u>fa</u>                  |  | Be C           | 25. Was case referred to medical  |   |                                 |                         |                              | 26 Place of De                         | 1 ☐ Ye<br>eath (Check on             |                             | 1 Ye                              | s 2 No                                    |             |
| <u> </u>                   |  | To B           | examiner? 1 Yes 2 No  | ospital: 1 Inpatient 2  | ER/Outpatier                    | nt 3 🗆 🖸                | Othe                         | AC                                     | Home 5 □ R                           |                             | 6 □Other (So                      | ecify)                                    |             |
| 0                          | g Physer this seral di   |                | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of                    |                         | 28c. Injury<br>Work          |  | 28d. Descrit                         |                             |                                   |   |             |
| Ö                          | Attending r death. ector: After by the funer   | atio           | 1 ☑Natural 5 ☐ Pending<br>2 ☐ Accident investigation  | (Month, Day 16a)  | Injury                          | М                       |                              | r<br>res 2 □ No                        |                                      |                             |                                   |   |             |
| Division of Vital Records, | Atte   | ertification:  | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At he building, etc. (Specification)                         | ome, farm, str                  | eet, facto              | ory, office                  |  | 28f. Location                        | n (Street ar<br>Town, State | nd Number or F                    | Rural Route Nu                            | mber,       |
| Ö                          | s after<br>al Dire   | Cerl           | 4   | building, etc. (Special   |                                 |                         |                              |  | Ony or                               | rown, State                 | 7)                                |   |             |
|                            | To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral  | edicai         | 29a. Certifier 1 € Certifying Phys (Check only one)   | sician: To the best of my kno<br>ner: On the basis of examina<br>and manner stated. | wledge, death<br>tion and/or in | h occurre<br>vestigatio | d at the tim<br>on, in my op | e, date and place<br>pinion, death occ | e, and due to t<br>curred at the tim | he cause(s<br>ne, date an   | ) and manner a<br>d place, and du | is stated.<br>ie to the cause             | (s)         |
|                            | To the within 2 To the complet   | Me             | 29b. Signature and title of certifier   | . /   | 1                               | 2                       | 9c. License                  | number                                 |                                      | 29d. Da                     | te signed (Mor                    | nth, Day, Year)                           |             |
|                            |  |                | Buch  | An Al   | MAN                             |                         | D4                           | 376                                    |                                      | Ju                          | ne 1                              | 9 200                                     | 16          |
|                            | 10   |                | 30. Name and address of person who co   | mpleted cause of death (Item  | 23a) (Type,                     | Print)                  | /                            | * 11                                   |                                      |                             | 1                                 | 1)  | `           |
|                            | Sta  | to.            | Broderick J. 31. Date filed (Month, Day, Year)  | 32. Begistrar's Signa   | n M                             | 0                       | 210                          | rai Ho                                 | Spital                               | of                          | Dat                               | trnor                                     | e           |
|                            | Registr  |                | THE 3 0 20  | 106 Angues  | G. An                           | BULL                    |                              |  | -                                    |                             |                                   |   |             |

DHMH 17 Rev 1/2001

PT Known As Kenneth Femgioni

|  | 4                    | For State Registrar  | State of M  | Maryland / [                   | epartme<br>Certifica                        |  |                  | and Me                    |   | giene<br>Jieg. No. 2 (   | 06                   | 22588   |
|--|----------------------|--|---|--------------------------------|---|--|------------------|---------------------------|---|--------------------------|----------------------|---|
| Physicia   | _                    | Decedent's Name (First, Middle, i  |   | ian Downs                      | Garret                                      | :t   |                  |                           | 2. Date of Dea<br>Month   | Day                      | Year                 | 3. Time of Death                              |
| /Medic<br>Examine  |                      | 4a. Facility Name (If not institution, g   | rive street and number                                      | r)                             |   | y, Town, or                                | Location o       |                           | owig_   | 4c. Coun                 | ty of Death          |   |
| Funeral<br>Director  |                      | 5. Social Security Number 6 404-68-0919  |   | Age (In yrs. last bin          | thday) If Und<br>Month                      | er 1 Year                                  | If Under a       | 24 Hrs.<br>Min.           | 8. Date of Birtl<br>(Month, Day   | , Year <b>] 94</b> 6     | 9. Birth             | place (State or Foreign<br>intry)<br>(ansas   |
| Maryland -f show   |                      | Usual Residence of Decedent  10a. State 10b. County  PA Fult   | on  | 10c. City, Town                |   | dmore                                      | •                |                           |   |                          |                      | 10d. Inside City Limits 1 ☐ Yes 2 X No        |
| 3a or 28a  | Il Director          | 10e. Street and Number 1136 Barnhart   | Road  |                                | 10f. a                                      | ip Code                                    | L7238            |                           |   | 10g. Citizen of          | What Cou             | intry?  |
| 2 should be filed within 72 hours after deeth with the Maryland and Menial Hygiene. Is marked other then "naturel", or Iteme 23a or 28a-f show surnatic event, the Medical Examinar must be profitted at | by Funeral           | 11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏠 Divorced   | 12. Was Deceder Armed Force 1 1 Yes 2                       | s?<br>ŽNo                      |   | edent of Hi<br>ecify Cuba<br>2 <b>X</b> No |                  | gin? (Spec<br>n, Puerto P | cify Yes or No-<br>Rican, etc.)   | 14. Ra<br>Bl<br>Spec     | ack, White           | ican Indian,<br>, etc.<br>White               |
| within 72 hor<br>ane.<br>then "natura  | Completed            | 15. Decedent's<br>(Specify only highest<br>Elementary/Secondary (0-12)   | Education<br>grade completed)<br>College (1-40              |                                | Decedent's Us<br>(Give kind of life. DO NOT | vork done d<br>use retired                 | turing most<br>) |                           |   | 16b. Kind of             |                      |   |
|  | To Be Co             | 12<br>17. Father's Name (First, Middle, La<br>William T. G   | st)   |                                | Recrea                                      | icion                                      | 18. Mothe        | r's Name                  | (First, Middle,   | Maiden Suma              |                      | lministratio                                  |
| permit. Peges 1 and 2 should be Deperment of Health and Menta Important: If Item 27 is marked eny Injury or other traumatic e-   |                      | 19a. Informant's Name/Relationship  Sarah M. Morey  20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3  4 □ Donation 5 □ Other (Spe  | (Daughte  | 20b. Place of cemeter          | 4 S. Si<br>Disposition (A<br>y, crematory o | xth S<br>lame of<br>rother place           | St. Ri           | ichmo<br>Da<br>July       |   | diana 4<br>20c. Location | 17374<br>- City or T | own, State                                    |
| permit. P<br>Depertme<br>Importan<br>eny Injur.  |                      | 21. Signature of Funeral Service Lie   |   | MOIYIY                         |   | and Addres                                 | s of Facilit     | •                         | J.L.  | Davis                    | Funer                | Maryland<br>cal Home<br>and 21783             |
| ate be<br>nysicia<br>he bur  | Ical Examiner        | 29a. Fant. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a   | as a consequence               | AZ<br>of):                                  |  | g, such as       |                           | •   | est.                     |                      | Approximate Interval Between Onset and Death  |
| death certific<br>e attending p<br>ed for use as   | Physician/Medical    | IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 □ No 9 □ Unknown  |   | 2 Fetal death at time of death | 3 ☐ Ectopic<br>5 ☐ Other                    |  |                  |                           |   |                          | ate of deliv         | rery<br>Day Year                              |
| e ge   | ۵                    | Part II. Other significant condition   | s contributing to death                                     | a but not resulting in         | the underlying                              | cause give                                 | en in Part I.    |                           |   | bacco use co             |                      | the cause of death?                           |
| : The law re<br>cate has been<br>page 2 sho  | Completed            |  |   |                                |   |  |                  |                           | 24a. Was a autop perior   | med?                     | death?               | opsy findings available ompletion of cause of |
| or Attending Piter death. Director: After tin by the funera  | Certification: To Be | 25. Was case referred to medical examiner?  1  | tion<br>t be 28e. Place of                                  | njury 28b.                     | Firme of njury M                            | 28c. Injun<br>Worl                         | er: 4□Nu         | rsing Hom                 | (Check only of the 5 Reside Reside Rescribe has Rescribe has Rescribe has Rescribe Rescribe Rescribe Rescribe Research Res | ence 6 00                | urred                | fy)<br>al Route Number,                       |
| To the Hospital within 24 hours e To the Funeral Completely filled   | edical               | (Check only 2   Medical Ex   | Physician: To the be<br>taminer: On the basis<br>and manner | of examination an              | d/or investigati                            | on, in my o                                | oinion, deal     | d place, a<br>th occurre  | d at the time, o  | date and place           | , and due t          | to the cause(s)                               |
| To the within 2 To the complet   | M                    | 29b. Signature and title of certifier  Muchael   | J. Mus  | don't live on                  | no  | 9c. License                                | 1 / 6 6          | 7                         |   | 29d. Date sign           |                      |   |
| 47<br>Sta  | te                   | 31. Date filed (Month, Day, Year)  | MCCo med  | L ////D                        | Ned   | ied  | lay              | nus                       | Rel   | Meser                    | Fow.                 | no.   |
| Registr  |                      | JUL 0 7  | 2006  | see D.                         | Bourse                                      | 1  |                  |                           |   |                          |                      |   |

|  |                | 1 - For State   | State                | of Maryla  |                            | artment of                              |                   |                 |                               | 20                         | 0.6                             | 22500                                      |
|--|----------------|---|----------------------|--|----------------------------|---|-------------------|-----------------|-------------------------------|----------------------------|---------------------------------|--|
|  |                | Registrar  1. Decedent's Name (First, Mide  | dle, Last)           |  |                            | Timeate of                              | Death             |                 | 2. Date of Deal               | eg. No.                    | UD                              | 3. Time of Death                           |
| Physi  |                | Perry Eve   | erett                | Glotfel  | tv                         |   |                   |                 | Month<br>July                 | 5, 2006                    | Year                            | 4:40 p M                                   |
| /Med<br>Exam   |                | 4a. Facility Name (If not instituti   | on, give street and  |  |                            | 4b. City, Town,                         | or Location       | of Death        |                               | 4c. County                 |                                 |  |
|  |                | Dennett Road  | Manor Nu             | rsing Ho   | me                         | Oak:                                    | land              |                 |                               |                            | Garr                            | ett  |
| Funera<br>Directo  |                | 5. Social Security Number 215-26-6481   | 6. Sex<br>1 X M 2 □  |  | i. last birthday<br>2 Yrs. | Months Days                             |                   | 24 Hrs.<br>Min. | 8. Date of Birth (Month, Day) | 913                        | Cou                             | place (State or Foreign<br>ntry)<br>ryland |
| p ,  |                | Usual Residence of Decedent  10a. State 10b. Coun   |                      | 100.0  | ·                          |   |                   |                 |                               |                            |                                 |  |
| aryla<br>shov  | 7              |   | ,                    | 100.0  | ity, Town or L             |   |                   |                 |                               |                            |                                 | 10d. Inside City Limits 1 ☐ Yes 2 XNo      |
| the M  | Director       | MD<br>10e. Street and Number  | Garrett              |  |                            | McHenry                                 |                   |                 |                               | 0g. Citizen of             | A/I 4 C                         |  |
| with   |                |   |                      |  |                            | TOT. ZIP COUP                           | 21                | E /. 1          |                               | og. Cilizen or             |                                 | muy ?                                      |
| death<br>ms 23   | Funeral        | 1111 James Wa   | 12. Was E            | Decedent Ever in 1                                 | U.S. 13.                   | Was Decedent of                         |                   | 541             | ecify Yes or No-              | 14. Rac                    | USA<br>ce - Amen                | ican Indian,                               |
| If E, INIAL PIGITION AND INCOME.  Is 1 and 2 should be filled within 72 hours after death with the Maryland of Health and Mental Hygiene.  Item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, ite Medical Examination must be notified at | by Fur         | 1 Never Married 2 Ma  | rried 1 X Y          | d Forces?<br>es 2 ☐ No<br>, Give<br>or Dates: 43-4 |                            | If Yes, specify Cult  1 ☐ Yes 2 No      | ban, Mexicar      | n, Puerto       | Rican, etc.)                  |                            | ck, White,                      |  |
| 2 hours a  |                | 15. Decede  | ent's Education      |  |                            | edent's Usual Occu                      | ipation           |                 |                               | 16b, Kind of B             | usiness/Ir                      | ndustry                                    |
| D 7 nin 7  | Completed      | (Specify only high<br>Elementary/Secondary (0-12)   | est grade complete   | ed)<br>je (1-4or 5+)                               | (Give                      | b kind of work done DO NOT use retire   | during mos<br>ed) | t of work       | ing                           |                            |                                 | ,  |
| d with   | E E            | 10  | Colleg               | 10 (1-401 54)                                      | Own                        | er                                      |                   |                 |                               | S                          | ales                            |  |
| d be file<br>antal Hy<br>red other   | Be             | 17. Father's Name (First, Middle  | e, Last)             |  |                            |   | 18. Mothe         | er's Name       | First, Middle, i              | Maiden Suman               | ne)                             |  |
| Ments<br>Ments<br>arked  | 2              | Archibald   |                      | Glotf  | elty                       |   | Li1               | 1у              | Katie                         | e S                        | uter                            |  |
| VICE<br>12 sho<br>h and<br>7 ls m  |                | 19a. fnformant's Name/Relation  |                      |  |                            | ing Address (Stree                      |                   |                 |                               |                            | State, Zij                      | p Code)                                    |
| and and the alth   |                | Nancy Bernard   | l/ Daught            |  |                            |   | , МсНе            |                 |                               |                            |                                 |  |
| Pages 1  |                | 20a. Method of Disposition 1   ↑ Burial 2 □ Cremation   |                      | om State   | cemetery, cre              | osition (Name of<br>matory or other pla |                   |                 |                               | 20c. Location              |                                 |  |
| Dall IIIIOI Dermit. Pages Depertment of mportant: If It my Injury or o   |                | 4 Donation 5 Other  | 1                    | Ga   |                            | Co. Mem.                                |                   |                 | 06<br>Stewart                 | Oaklan                     |                                 |  |
| Dallimore, permit. Pages 1 an Department of Heal Important: If Item 2 eny Injury or other  | ouce           | 21. Signature of Funeral Service  | M M                  |  |                            | 2. Name and Addr<br>2 S. Seco           |                   | •               |                               |                            |                                 | ше   |
|  | 1              | 23a. Part 1. Enter the disease,   | or complications th  | at caused the dea                                  |                            |   |                   |                 |                               |                            | JU                              | Approximate                                |
| Physicia:<br>/Medica   |                | shock, or heart failure. Li<br>fmmediate Cause (Final<br>disease or condition<br>resulting in death)  | st only one cause of | on each line.                                      |                            | cerebro                                 |                   |                 |                               |                            |                                 | Onset and Death                            |
| Examine  | er             | and the state of the state of   | 9.4                  | herosula   | ritiz                      | Cerchin                                 | 10 30.11          | 142             | disea                         | se                         |                                 | 10 40010                                   |
|  | Je J           | Sequentially list conditions, if any, leading to immediate  |                      | 67   |                            |   |                   | · Justs         |                               |                            |                                 |  |
| icate be executed physicien end sthe burial-transit  | Examiner       | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events  | <b>)</b> c           |  |                            |   |                   |                 |                               |                            |                                 |  |
| e exe  | Ä              | resulting in death) Last  | Due                  | to (or as a conse                                  | equence of):               |   |                   |                 |                               |                            |                                 |  |
| ate be e<br>ste be e<br>shysicien<br>the buriz   | dical          |   | d                    |  |                            |   |                   |                 |                               |                            | -                               |  |
| I RECORDS, P.O. BOX 05/00,  The law requires that the death certificate be executed at has been signed by the attending physicien end page 2 should be detached for use as the burial-transit  | /Med           | IF FEMALE:  | 23c If yes           | outcome of pregr                                   | 02001                      |   |                   |                 |                               |                            |                                 |  |
| Bath cattern   | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?   | 1⊡Li                 | ve birth 2 ☐ Fei<br>regnant at time of             | tal death 3                | ☐Ectopic pregnand ☐ Other (specify)     | су                |                 |                               |                            | te of deliver                   | ery<br>Day Year                            |
| the d  | yslc           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   |                      | nknown   | Obatii 5                   | Other (specify)                         |                   |                 |                               |                            |                                 |  |
| that ned by deta   |                | Part II. Other significant condi  | tions contributing   | to death but not re                                | sulting in the             | underlying cause g                      | ıven in Part I    |                 | 23e. Did tol                  | pacco use con              | tribute to t                    | the cause of death?                        |
| wrequires to been signed should be a   | d by           | Deneu tio,  | senile               | ense-t   | diel                       | eta m                                   | e/1it.            | 21              | 1 🗆 Ye                        | s 2 No                     | 3 🗌 Prol                        | babfy 4 Unknown                            |
| w rec  | lete           | Lune two.   | o thora              | Sclovet  | ish L                      | ordivo.                                 | 1 4/6             | 4-              | 24a. Was a                    | n 24b.                     | Were auto                       | opsy findings available                    |
| Of VICAL HEC<br>Physician: The lav<br>this certificate has<br>ral director, page 2:  | Completed      | arease.   | 11.04                | Cha C  | ec L                       | ,                                       |                   |                 | autops                        | ned?                       | prior to co<br>death?<br>1  Yes | ompletion of cause of                      |
| VITAL ician: 1 certificat ector, p   | 0              | 25. Was case referred to medic  | af A                 | J. Mer po  | CHOPI                      |   | 26. Place         | of Death        | 1 ☐ Yes :                     | 7                          | T T es                          | 2   NO                                     |
| ysici<br>nysici<br>nis ce<br>direc   | To B           | examiner?<br>1 ☐ Yes 2 ☑ No   | Hospital:            | ☐ fnpatient 2 [                                    | ☐ ER/Outpatie              | nt 3 DOA                                |                   |                 | me 5 Reside                   |                            | ner (Speci                      | fy)  |
| n Of<br>ng Phy<br>fter this  |                |   |                      |  |                            |   |                   |                 |                               |                            |                                 |  |
| SIO<br>eath.<br>or: A  | catle          | 2 Accident investigation M 1 Yes 2 No   |                      |  |                            |   |                   |                 |                               |                            |                                 |  |
| LIVISION If or Attending after death. Director: Afte   | Certification: | 3 Suicide 6 Could not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num City or Town, State)   |                      |  |                            |   |                   |                 |                               |                            | al Route Number,                |  |
| UNISION OF VICA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.   |                | 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                      |  |                            |   |                   |                 |                               | stated.<br>to the cause(s) |                                 |  |
| o the<br>o the   | Med            | 29b. Signature and title of centre  |                      | - July States                                      |                            | 29c. Licer                              | nse number        |                 | 2                             | 9d. Date signe             | d (Month,                       | Day, Year)                                 |
| F ₹ F ŏ  |                | V Million   | 871                  |  | MB                         | 12/1                                    | 1125              | 754             |                               |                            |                                 |  |
| 0.112  |                | 30. Name and address of person  | on who completed     | cause of death (Ite                                | em 23a) (Type              | Print)                                  | /                 |                 | do at                         | july "                     | 1-6                             |  |
| 84VA   |                | welterk.  | Nauma.               | 40   | ). Pc                      | Bux 2                                   | 47. A             | ein             | dent                          | MD2                        | 152                             | 0  |
| 11 202   | State          | 31. Date filed (Month, Day, Yea   |                      | 2. Registrar's Sign                                | nature                     |   |                   |                 |                               |                            |                                 |  |
| Regi   | strar          | JUL   | 1 1 2006             | Congress .   | 0 8                        | A 30 6 D                                |                   |                 |                               |                            |                                 |  |

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician July 8, GUTHRIE Louise 2006 5:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 2733 Shady Dell Road Oakland Garrett If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Yrs. 64 Dec. 1, 1941 **Director** Pennsylvania 233-64-8073 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 10b. County 1 ☐ Yes 2 No Director MD Oakland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2733 Shady Dell Road 21550 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Item prizery or other traumatic event, Item Medical Exercitations. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife. Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harold Strawser Mary Ellen Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William Guthrie/Son 2733 Shady Dell Road, Oakland, Maryland 21550 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ashby Cemetery 7/11/06 4 ☐ Donation 5 ☐ Other (Specify) Oakland, Maryland 21. Signalate of Funeral Services 22. Name and Address of Facility 32 S. Second St. Stewart Funeral Home Oakland, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part1, Enter the disease. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🎇 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown dr 1 case Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificete 1 Yes 2 No or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1. Natural Injury 5 Pending investigation 2 Accident d in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or to the Funeral Direct completely filled in by filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medica (Check only 29b. Signature and title dicertines 29d. Date signed (Month, Day, Year) 29c. License number 2006 10033280 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lo Dr. Sunil K. Gupta, MD 625 Kent Ave., Cumberland, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 1 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

|             |  |                | 1 - For<br>State<br>Registrar  | State of Ma   |                                |                                      | ent of Hea<br>ate of De             |                                   |                                   | giene.                       | 006   | 2259  | )         |
|-------------|--|----------------|--|---|--------------------------------|--------------------------------------|-------------------------------------|-----------------------------------|-----------------------------------|------------------------------|---|---|-----------|
| S.          | . Physici  | an             | Decedent's Name (First, Middle,  | Last)   |                                |                                      |                                     |                                   | 2. Date of De<br>Month            | ath<br>Day                   | Yea <i>r</i>  | 3. Time of Dear                                   | th        |
|             | /Medi  |                | Floyd H. Ga  |   |                                |                                      |                                     |                                   | June                              | 25                           | 2006  | 2226  | M         |
| -           | Examir   | ier            | 4a. Facility Name (If not institution,   |   |                                | 4b. C                                | ty, Town, or Loc                    |                                   |                                   | 4c. Co                       | ounty of Death                                      |   |           |
| k)          | ·  | Seg.           |  | ryland Hosp:  | ital<br>(In yrs. last bir      | thday) If Un                         |                                     | inton<br>Under 24 Hrs.            | 8. Date of Bir                    | th.                          |   | George's  |           |
|             | Funeral Director   |                | 579-64-0850  | 1 <b>X</b> □M 2□F   |                                | Yrs. Month                           |                                     | ours Min.                         | (Month, Da                        | y, Year)                     | 6 Te  | lace (State or For<br>try)<br>EXAS                | ugn       |
|             | D .  |                | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, Town                |                                      |                                     |                                   |                                   |                              |   |   |           |
|             | Aaryla<br>Febor  | or             | Maryland Prince  | George's  | TOC. City, Town                | n or Location                        | S                                   | Buitlan                           | d                                 |                              | 1   | 0d. Inside City Lin 1 X Yes 2 □                   |           |
|             | 28a-   | Directo        | 10e. Street and Number   | ocorge 5  |                                | 10f                                  | Zip Code                            |                                   |                                   | 10g Citizer                  | n of What Coun                                      |   |           |
|             | 3a or  | Ö              | 3942 Suitland  | Rd #201   |                                |                                      |                                     | 20746                             |                                   |                              | Inited S  | •   |           |
|             | death  | Funeral        | 11. Marital Status   | 12. Was Decedent E  | ver in U.S.                    | 13. Was De                           | cedent of Hispar                    |                                   | pecify Yes or No<br>Plican, etc.) |                              | Race - Americ                                       | an Indian,  |           |
| 9           | or the   | /Fu            | 1 Never Married 2 Married  | Armed Forces? 1 ☐ Yes 21 N If Yes, Give                                     | 0                              |                                      | pecity Cuban, M<br>2□XNo Sc         |                                   | Hican, etc.)                      |                              | Black, White,                                       | etc.<br>Black                                     |           |
| 21215-0036  | 2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Is marked other than "natural", or itema 23a or 28e-f ehow aumatic evant, the Medical Expoliner count be notified at   | d by           | 3 Widowed 4 Divorced   | Year or Dates:  |                                |                                      |                                     |                                   |                                   |                              |   |   |           |
| 7           | n 72   | Completed      | 15. Decedent's<br>(Specify only highest  | Education<br>grade completed)   | 16a.                           | Give kind of life. DO NO             | sual Occupation<br>work done during | g most of work                    | king                              | 16b. Kind                    | of Business/Inc                                     | lustry  |           |
| 712         | with<br>iene.  | шо             | Elementary/Secondary (0-12)  | College (1-4or 5-   | +)                             |                                      | rogram                              | Analys                            | +                                 | ΈΡΔ                          | - Gove  | cnment  |           |
| פ           | a filed v<br>It Hygie<br>other t   | a u            | 17. Father's Name (First, Middle, La   | st)   |                                |                                      | -                                   |                                   | e (First, Middle                  |                              |   | Innerre   |           |
| <u>Iar</u>  | should be<br>ind Mental<br>marked o  | To B           | Floy   | d H. Gayles   | , Sr.                          |                                      |                                     |                                   | F1o                               | rence                        | Taylor  |   |           |
| Maryland    | s 1 and 2 should<br>f Health and Mer<br>item 27 is marks<br>other traumatic  |                | 19a. Informant's Name/Relationship   |   |                                |                                      |                                     |                                   | al Route Numb                     |                              |   |   |           |
|             | l and i  |                | Daisy D. Gayl  | es/Wife   | -                              |                                      | tland R                             |                                   |                                   |                              | l, MD   |   |           |
| altimore,   | Pages 1 ar   |                | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3  |   | 1                              | Disposition (A<br>ry, crematory of   |                                     | 1                                 | Date                              |                              | ion - City or To                                    |   |           |
| ===         | iit. Partmer   |                | 4 □ Donation 5 □ Other (Spe<br>21. Signature   Funeral Service Lice  |   | Harmo                          | -                                    | rial Pa                             |                                   | 1/2006<br>Stewart                 |                              | ndover  |   |           |
| Ba          | permit. Pages<br>Department of<br>Important: If it<br>eny injury or o  |                | The Late of the La | (town t   | TILL                           | ZZ. Name                             |                                     |                                   | Rd., NE                           |                              |   |   |           |
| 3           |  |                | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on   | emplications that caused  | the death. Do r                | not enter the m                      |                                     |                                   |                                   |                              | 1, 20   | Approximate<br>Interval Between                   |           |
| - 5         | death certificate be executed  Medical  Ex  Medical  Medi | ilcal Examiner | Immediate Causé (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b. Acuto Due to (or as a d. | consequence                    | of):                                 | 0                                   |                                   | eha.                              | د                            |   | Onset and Death                                   |           |
| P.O. Box 6  | it the death certifice<br>by the attending ph<br>tached for use as t   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown      | Fetal death                    | 3 □Ectopic<br>5 □ Other (            |                                     |                                   |                                   | 23d                          | . Date of deliver<br>Month                          | y<br>Day Year                                     |           |
| rds, r      | quires that<br>n signed t<br>uld be det  | by             | Part II. Other significant conditions  | s contributing to death bu  | t not resufting in             | the underlying                       | cause given in                      | Part I.                           |                                   |                              |   | e cause of death?                                 |           |
| al Records, | iclen: The law requires that the certificate has been signed by the rector, page 2 should be detache   | Completed      |  |   |                                |                                      |                                     |                                   | 1 Yes                             | rmed?<br>2 B No              | 4b. Were autop<br>prior to com<br>death?<br>1 ☐ Yes | sy findings availa<br>pletion of cause (<br>2  No | ble<br>of |
| Ĭ           | siclen:<br>certific<br>irector,  | o Be           | 25. Was case referred to medical examiner?  1 Yes 2 No   | Hospital:   | · offeno                       | tpatient 3 1                         | 1 Oth                               |                                   | Check only o                      |                              |   |   | _         |
| ō           | Attending Physicien: r death. sctor: After this certific. by the funeral director.   | n: To          | 27. Manner of Death  | 1 ☐ Inpatien  | 28b. T                         | ime of                               | 28c. Injury at<br>Work?             |                                   | me 5 Resid                        |                              |   | )   |           |
| <u>0</u>    | nding Path.  | atio           | 1 Matural 5 ☐ Pending<br>2 ☐ Accident investigat   | (Month, Day   | Year) Ir                       | njury<br>M                           | Work?<br>1 ☐ Yes                    |                                   |                                   | . ,                          |   |   |           |
| É           | el or Attendi<br>after death.<br>I Diractor: A<br>d in by the fu   | Certification: | 3 Suicide 6 Could not determine  | 28e. Place of Injurbuilding, etc.   | ry - At home, far<br>(Specify) | rm, street, facto                    | pry, office                         |                                   | 28f. Location (S<br>City or Tox   | Street and N<br>vn, State)   | umber or Rural                                      | Route Number,                                     |           |
|             | To the Hospitel or At<br>within 24 hours after of<br>To the Funeral Direct<br>completely filled in by  | edical (       | 29a. Certifier (Chack only one) 1 Certifying (Chack only one)  | Physician: To the best of annings. On the basis of and manner state         | examination and                | , death occurre<br>Vor investigation | d at the time, da                   | ate and place,<br>n, death occurr | and due to the red at the time,   | cause(s) and<br>date and pla | d manner as sta<br>ce, and due to                   | ited.<br>the cause(s)                             |           |
|             | To the within 2 To the complet   | Me             | 29b. Signature and title of certifier  | / 0   |                                | 2                                    | 9c. License num                     | nber                              |                                   |                              | gned (Month, D                                      |   | -         |
|             |  |                |  | alo.  | . ~                            | 7 1                                  | 2004                                | 158                               | 0                                 | 06/                          | 27/0  | 16  |           |
|             | (6)  |                |  | o complete use of de  |                                | Type, Print)                         |                                     |                                   |                                   | •                            |   |   |           |
| _           | V  |                | Scott Kels   | 7.72  |                                | ratts l                              | Road, C1                            | Linton,                           | MD 20                             | 703                          |   |   |           |
|             | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)  JUL 0 3 20  |   | r's Signature—                 | berte                                |                                     |                                   |                                   |                              |   |   |           |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Day Physician Year Mary Matthews Guyther Ju<sub>1y</sub> 2006 8:10 a.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 40914 Lake & Breton View Drive St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F Months Director 215-32-6167 73 May 22, 1933 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No St. Mary's Direct Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 'natural', or items 23a 40914 Lake & Breton View Drive 20650 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. within 72 hours after 1 □ Never Married 2 □ Married ☐Yes 2 No 1 ☐ Yes 2 ₽ No If Yes, Give Year or Dates: Specify þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: filem 27 is marked other than eny injury or other traumatic access. Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Agent Real Estate 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Ryan Matthews Leoma Clarke Coppage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Hoy/Daughter 1021 Wiltshire Drive, La Plata, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Francis Xavier 7-15-2006 Leonardtown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, 22955 Hollywood Road, Leonardtown, MD 20650 M00052 Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** ancreah tmonths /Medicat resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown į Day Year 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown cete hes been signated to page 2 should to 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has funeral director, page 2 autopsy performed? Yes 2 No 1 🗌 Yes 1 ☐ Yes 2 ☐ No Physicien: 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospitel or Attending 1 Natural 5 Pending Injury within 24 hours after death.

To the Funerel Director: A completely filled in by the fu М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai Check unity onel 5

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

State Registrar

Z4035 THREE NOTCH ROAD HOLLYWOOD MD UPPAL 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

NIKHIL

29c. License number

D0062288

29d. Date signed (Month, Day, Year)

20636

7/12/06

State of Maryland / Department of Health and Mental Hygiene 2 🕦 🕦 🕞 State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month June Da 28, 2006 3:20 P<sub>M</sub> **Physician** Gordon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Kingshire Assisted Living Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 2 4 21 9. Birthplace (State or Foreign Country) Wash. DC 5. Social Security Number **Funeral** Months Days Hours Min 1 □ MM 2 □ F 578-12-1207 84 Yrs. Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State rat", or itema 23a or 28e-f ahow Exeminer must be notified at Y☐ Yes 2 ☐ No Montgomery Silver Spring Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 U.S.A. 10708 Tenbrook Drive filed within 72 hours after death by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Wes 2 ☐ No If Yes, Give Year or Dates: WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) I Hygiene. Men's Wear Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of r traumatic avair Pages 1 and 2 should be William S. Gordon Sadie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12724 Murphy Grove Terrace Clarksburg MD 20871 Evelyn G. Pyrdol - Daughter if item 27 i inkrougher in 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t □ Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment o Important: If Mt. Lebanon Cemetery 6/30/06

22. Name and Address of Facility Edward Sage1 Funeral Direction Inc 4 ☐Donation 5 ☐ Other (Specify) 21. Signature Françai Service Licensee 1091 Rockville Pike Rockville MD 20852 Approximate
Interval Between
Onset and Pear 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Congestive Heart Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached to 1 Yes 2 No 9 🗆 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. Hypertension 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 █ No 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Chronic Kidney Disease this certificate had director, page 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Assisted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 28c. fnjury at Work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 Pending 1 Tyes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28656 June 29, 2006 30. Name in address of person who completed cause of death (ttem 23a) (Type, Print) Dr. Ravi Passi MD 8609 Second Avenue #404B Silver Spring MD 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature JUL 0 5 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|   | an   | 1. Decedent's Name   |  |  |  |  |   |  |  |  |  | 2. Date of I  | Da   |  | Year   | 3. Time  |                    |
|---|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--------------------|
| Medio   | cal  | Donald 4a. Facility Name (/:   |  |  | nd number)   |  |   | 4b City  | Town or  | Location of  | of Death                                     | 05  | 30   | 200<br>c. County of  |  | 8:0  | 5 A                |
| camir   | ier  | St. Vin  |  |  |  | a Co   | nton  |  |  |  |  |   |  | llega  |  |  |                    |
| neral   |  | 5. Social Security N   | lumber   | 6. Sex<br>12 M 2   | 7. Ag  | e (In yrs.   | last birthday   | /) If Under  | Stbu<br>r 1 Year<br>Days   | rg   V<br>Hunder<br>Hours                                | 24 Hrs.<br>Min.                              | 8. Date of 8  | Birth<br>Day Year  | n lega   | 9. Birtho  | lace (State  | or F               |
| ctor  |  | 235-52-53  | 301  | 1 <b>£3</b> M 2L   | JF   | 78   | Yrs.  | I WOTHING  | Days   | riodis   |  | 8. Date of 8 (Month, 1)   | 29,  | 1927 1   | West   | Virg   | gin                |
| **  |  | Usual Residence of<br>10a. State   | 10b. County  |  |  | 10c. Cit   | ty, Town or I   | ocation  |  |  |  |   |  |  | 1  | 0d. Inside   | City               |
| pail  | ğ  | WV   | Hamps  | hire   |  | Ro   | omney   |  |  |  |  |   |  |  |  | 1X Y   | - 1                |
| nott  | Funeral Director   | 10e. Street and Nur  |  | HILLE  |  | 110  | лшеу  | 10f. Zip   | p Code   |  |  |   | 10g. C   | itizen of Wh   | nat Coun   | ntry?  |                    |
| 4   | a D  | 450 Dep  | ot Stre  | et   |  |  |   | 20   | 6757   |  |  |   | 1  | U.S.   |  |  |                    |
| M I   | ner  | 11. Marital Status   |  | 12. Wa:  | s Decedent   | Ever in U  | J.S. 13   |  |  | spanic Ori   | gin? (Spe                                    | ecify Yes or I<br>Rican, etc.)  |  | 14. Race -   |  |  |                    |
| Sup   |  | 1 Never Marri  |  | ied 1 [  | ned Forces?<br>Yes 2 21.1<br>es, Give  | No   |   | 1 🗆 Yes  | ~ ~  | Specify:   |  | r noart, etc.,  |  | Specify:   | White,   |  |                    |
| alEx  | d by   | 3 Widowed  |  | Yea  | r or Dates:  |  |   |  |  |  |  | _   |  |  |  |  |                    |
| Sign  | Completed  |  | 15. Decedent<br>cify only highes   |  | leted)   |  | (Giv  | edent's Usu<br>e kind of wo<br>DO NOT u  | ork done o   | lurina mos   | t of worki                                   | ng  | 16b. l   | Kind of Busi   | iness/Ind  | dustry   |                    |
| In M  | шо   | Elementary/Seco  | ondary (0-12)  | Col  | lege (1-4or 5  | i+)  | 1   | bor  | .00 .0100  | ,  |  |   | She  | oe fac   | ctor   | 77   |                    |
| any injury or other treumetic event, the Musical Examinar must be notified at once. | a)   | 17. Father's Name  |  | Last)  |  |  |   |  |  | 18. Mothe  | er's Name                                    | (First, Mida  |  |  |  |  |                    |
| tic ev  | To B   | Irvin Ra   | ay Guli  | .ck  |  |  |   |  |  | Vani   | na Re  | ebecca  | Roge   | ers  |  |  |                    |
| emne  | -  | 19a. Informant's Na  | ame/Relations  | hip (Type, Prir  | nt)  |  | 19b. Mai  | ling Address   | s (Street a  |  |  | l Route Num   |  |  | tate, Zip  | Code)  |                    |
| er tre  |  | Betty Le   | ee   |  |  |  | _   |  |  | 31, R  | omney  | y, WV   | 2675   | 7  |  |  |                    |
| or oth  |  | 20a. Method of Disp  | position   | 3 □Remova  | I from State   | 20b. F   | Place of Disp<br>cemetery, cr   | oosition (Nai<br>ematory or d  | me of<br>other plac  | 9)   |  | ate   | 20c. L   | ocation - Ci   | ity or To  | wn, State  |                    |
| ury o   |  | `4 □Donation   |  |  | THOM OLDES   | Mt.  | . Unio  | n Ceme   | etery  | 7  | June   | 1, 20   | 06 3   | S1anes   | svi1   | le, W  | IV                 |
| ny inj  |  | 21. Signature of Fu  | ineral Service I   | Licensee   | 1-   | /  | / 3   | 22. Name ar  | nd Addres  | s of Facilit   | y<br>La Elan                                 | neral   | Uomo.  |  |  |  |                    |
| <b>6</b> Ol   |  | Jev.   | mes  | 7 4  | cay  | 01/0   | ~   | 230 E.   | . Mai  | in St  | . Ro   | nmnev   | TATE *   | 26757  |  |  |                    |
|   |  |  | he disease, or<br>art failure. List  | complications<br>only one caus   | that caused  | the deat   | th. Do not er   | nter the mod   | de of dying  | g, such as   | cardiac o                                    | r respiratory   | arrest,  |  |  | Approxim<br>Interval B   | ate<br>etwe        |
| Acres 1   |  |  |  |  |  | 10.  |   |  |  |  |  |   |  |  |  |  | 4 Da               |
| cian i  |  | Immediate Cause (<br>disease or condition<br>resulting in death)   |  | a  | Seps   | 15   | synd  |  |  |  |  |   |  |  |  | Onset and  | d Dea              |
| dical<br>iner   |  |  |  | ( a  | Sep s  | 15<br>a conseq   | 3 yn c  | romu   | ٥  |  |  |   |  |  |  |  | Dei                |
| lical   | er   | disease or condition resulting in death)   | òn   | b  | Seps   | 15<br>a conseq   | 3 yn c  |  |  |  |  |   |  |  |  |  | y,                 |
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| lical iner transit the private stransit   | dicai  | disease or condition resulting in death)  Sequentially list confidence of any leading to incause. Enter Under Cause (Disease or that initiated events resulting in death) I  | inditions, module strying injury schang strying straint trends to pregnant   | b  | Seps<br>abdo<br>Abdom<br>ue to (or as<br>Statu   | a consequence of pregna 2 Feta   | ancy  | Pen<br>artmen<br>Latera  | Wount Synt in  | md<br>ndrom  | ne<br>1 he                                   |   | Surge  | 23d. Date  | AL EXAMI   | Onset and  | y,                 |
| for use as the burial-transit   | dicai  | disease or condition resulting in death)  Sequentially list confiance. Enter Under Cause, Enter Under Cause (Disease or that initiated events resulting in death) I  | inditions, mediate stying injury state to regnant months?  | b  | Sep Some to (or as abdome to (or as Abdome to (or as Statu   | a consequence of pregna 2 Feta   | ancy  | en<br>ertmen   | Wount Synt in  | md<br>ndrom  | ne<br>1 he                                   |   | surge<br>APPROVE   | 23d. Date of Month   | AL EXAMINATION Of delive   | 2 de   | y;                 |
| iner as the burial-transit  | Physiclan/Medical  | disease or condition resulting in death)  Sequentially list confidence of the sequence of the  | inditions, module stying injury s Last   | b  | Sep Solue to (or as Abdom Due to (or as Status)  ses, outcome Live birth Pregnant at Unknown   | minal a consequence s poor   | ancy al death 3 Jeath 5   | Pen<br>artmen<br>latera  | Wount Synt Indian  | md<br>ndrom<br>guina                                     | ne al ho                                     | tud<br>RTIFICATION  | APPROVE  | 23d. Date (  |  | Onset and  | Yea                |
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| should be detached for use as the burial-transit                                    | by Physiclan/Medicai                                       | disease or condition resulting in death)  Sequentially list confidence of the sequence of the  | inditions, module stying injury s Last   | b  | Sep Solue to (or as Abdom Due to (or as Status)  ses, outcome Live birth Pregnant at Unknown   | minal a consequence s poor   | ancy al death 3 Jeath 5   | Pen<br>artmen<br>latera  | Wount Synt Indian  | md<br>ndrom<br>guina                                     | ne al ho                                     | RTIFICATION  239. Dic   | APPROVE  | 23d. Date of Month   | ute to th  | Onset and  | Yea<br>deat        |
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DHMH 17 Rev 1/2001

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|            |                     |  | 1              | State of Maryland / Department of Health a  For State Registrar  Certificate of Death  |   | Reg. No. 24595   |
|------------|---------------------|--|----------------|--|---|--|
|            |                     | Physicia   |                | Decedent's Name (First, Middle, Last)  | 2. Date of Do<br>Month                                    | Day Year   |
|            |                     | /Medic   | al             | Marian Elizabeth Gartland  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of  | June<br>of Death  | 25, 2006 5:55 P  |
|            |                     | Examili  | CI             | Homewood Nursing Home Fredrick   | 24 455 10 0 1 40  | Fredrick   |
| 9          |                     | Funeral<br>Director  |                | 5. Social Security Number  6. Sex 1 M 2 St P  7. Age (In yrs. last birthday) Yrs.  7. Age (In yrs. last birthday) Yrs.  1 Oder 1 Year If Under 1 Year Hours  | 24 Hrs.<br>Min.<br>8. Date of Bi<br>(Month, D<br>Sept. 1) |  |
| 52         |                     | ਰ  |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  | БСРСТ   | 10d. Inside City Limits  |
| .5         |                     | Maryla<br>f shov   | tor            | West VA. Morgan Berkeley Springs   |   | 1 <b>∑</b> Yes 2 □ No  |
|            |                     | th the or 28a  | Director       | 10e. Street and Number 10f. Zip Code   |   | 10g. Citizen of What Country?  |
| á          |                     | death with the Maryland<br>ims 23a or 28a-f show<br>ir nust be notified at   |                | 283 Little Creek     Lane     25411       11. Marital Status     12. Was Decedent Ever in U.S. Armed Forces?     13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar   | gin? (Specify Yes or N                                    | U.S.A.  14. Race - American Indian,  |
|            |                     | ours after death with the Marylan<br>ral', or Itams 23a or 28a-1 show<br>Exerticer must be notified at   | Funeral        | Armed Forces? If Yes, specify Cuban, Mexicar  1 Never Married 2 Married In Yes 2 No If Yes, Sirve In Yes 2 No If Yes, Sirve In Yes 2 No If Yes, Sirve In Yes, Specify:   |   | Black, White, etc.  Specify: White   |
| )          | Maryland 21215-0036 | 2 should be filed within 72 hours after dea<br>and Mental Hygiene.<br>Is marked other than "natural", or Itams<br>'aumatic event, It's Madical Exemiter in   | ed by          | 3⊠Widowed 4 □Divorced Year or Dates:   |   | 16b. Kind of Business/Industry   |
|            | 215-                | hin 72<br>an "nat  | Completed      | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  | t of working  |  |
| و          | 21                  | led with   | Com            | 12 Homemaker   | er's Name (First, Middle                                  | Own Home   |
| 0          | and                 | id be fi<br>ental H<br>ked ot<br>ic ever   | To Be          | 17.1 auto 3 realite (7 75t, minuto, east)  | a Kenyon  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  |
| 10/52/01   | ary                 | and M  | -              | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number  | er or Rural Route Numi                                    |  |
| 9          |                     | 1 and 3  | į,             | Joan E. Hopkins / Daughter 283 Little Creek  20a. Method of Disposition 20b. Place of Disposition (Name of commetery, crematory or other place)  | Lane Berke.   | ley Springs, WV 25411  20c. Location - City or Town, State                     |
| Ca         | TOL                 | ages<br>ant of h   |                | TYXBurial 2 (Cremation 3 Li Hemoval from State)  | une 28, 06  | Silver Spring, Md  |
| 0          | Baltimore,          | permit. Pages I and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury of other traumatic event, Ita Madicanonce. |                | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility   | ty Joseph G   | awler's Sons, INC.<br>Wash. D.C. 20016   |
| <u>_</u> ! |                     |  |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as   | cardiac or respiratory                                    | arrest, Approximate<br>Interval Between  |
|            |                     | Physician  | l p            | Immediate Cause (Final disease or condition  | Heart   | Onset and Death VG(  |
| 2          | 5                   | /Medical<br>Examiner   |                | resulting in death)  Due to (or as a consequence of):  |   |  |
| Č          |                     |  | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.   |   |  |
|            | 3                   | be executed<br>sician and<br>burial-transit  | Examiner       | Cause (Disease or injury that initiated events c. Due to (or as a consequence of):   |   |  |
| 8          | 8760, March         | te be executed<br>ysician and<br>ie burial-transit   | calE           | d  |   |  |
| ari        | 9                   | artificat<br>ing phy<br>e as th  |                | IF FEMALE:   |   | COL Data of delivers   |
| 2          | Вох                 | requires that the death certificate been signed by the attending physic hould be detached for use as the b   | iclan/Med      | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)   |   | 23d. Date of delivery  Month Day Year  |
| 3          | Ó.                  | that the di<br>ed by the<br>detached   | Physi          | 9 Unknown  | . On Die  | tobacco use contribute to the cause of death?                                  |
| 0          | JS, F               | ires the<br>signed<br>I be de  | b              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part  |   | Yes 2 No 3 Probably 4 Unknown  |
| 3          | Record              | w require<br>been sign<br>should b   | Completed      | A ct 5to - 267   | 24a. We   |  |
| Sich       |                     | The law<br>ate has b<br>page 2 sl  | omo            |  |   | formed? death?   |
| 5          | Vital               | Phyaician: The rthis certificate har ral director, page  | Be             | examiner? Hospital: Other  | e of Death Check on                                       | one sidence 6 □Other (Specify)   |
| 5          | ō                   | 를 들 교  | n: To          | 27. Manner of Death  28a. Date of Injury 2  28b. Time of Work?   |   | e how injury occurred  |
| 2          | sion                | Attending r death. sector: After by the fune   | catio          | 2 Accident Investigation M 1 Yes 2   |   | (Street and Number or Rural Route Number,                                      |
| 3          | Division            |  | Certification: | 3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide   | City or T   | own, State)  |
| NOW        |                     | To the Hospital or Attendwithin 24 hours after death within 24 hours after death To the Funeral Diractor: completely filled in by the  | edical C       | 29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date a (Check only one)    Certifying Physicien: To the best of my knowledge, death occurred at the time, date a construction of my knowledge, death occurred at the time, date a construction of my knowledge, death occurred at the time, date a construction of my knowledge, death occurred at the time, date a construction of my knowledge, death occurred at the time, date a construction of my knowledge, death occurred at the time, date a construction of my knowledge, death occurred at the time, date a construction of my knowledge, death occurred at the time, date a construction of my knowledge, death occurred at the time, date a construction of my knowledge, death occurred at the time, date a construction of my knowledge, death occurred at the time, date a construction of my knowledge, death occurred at the time, date a construction of my knowledge, death occurred at the time, date a construction of my knowledge, death occurred at the time, date a construction of my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and my knowledge, death occurred at the time, date and my knowledge, date at the time, date at the t | nd place, and due to the ath occurred at the time         | e cause(s) and manner as stated.<br>e, date and place, and due to the cause(s) |
| X          |                     |  | Me             | 29b. Signature and title of pertifier 29c. License number  |   | 29d. Date signed (Month, Day, Year)  |
|            |                     | 9  |                | MD D1642   | 28  | 4 27/06  |
|            |                     |  |                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Casper Cline, MD 300 West 9th ST Fredrick, Mary  | land 21701  | 1 (  |
|            |                     | St<br>Regis  | tate<br>trar   | 31. Date liled (Month, Day, Year)  JUN 3 0 2006  32. Negistrar's Signature   |   |  |
|            |                     | negis  | urar           | 3011 0 0 2000  |   |  |

Registrar

|   |   |                  | 1 - For<br>Registrar   | State of                     | Marylan                                      | nd / Depa<br><i>Cer</i>           | rtme<br><i>tifica</i>  | nt of H<br><i>te of L</i>               | ealth a<br>Death           | and M                      | ental Hy                             | gier<br>Reg. 1  |                      | 006                     | 22                             | 597        |
|---|---|------------------|--|------------------------------|--|-----------------------------------|------------------------|---|----------------------------|----------------------------|--------------------------------------|-----------------|----------------------|-------------------------|--------------------------------|------------|
|   |   |                  | 1. Decedent's Name (First, Middle, La                                  | st)                          | -  |                                   |                        |   |                            |                            | 2. Date of Do                        |                 | 2011                 | Year                    | 3. Time o                      | of Death   |
|   | hysici:<br>/Medic                                       |                  | Marion Marvin Gl   | adden, S:                    | r.   |                                   |                        |   |                            |                            | June                                 | 28              | Day 20               | 006                     | 8:30                           | ) A M      |
|   | xamin   |                  | 4a. Facility Name (If not institution, give                            | e street and numb            | er)  |                                   | 4b. Cit                | , Town, or                              | Location of                | of Death                   |                                      |                 | 4c. Cou              | nty of Death            | 1                              |            |
|   |   |                  | 8447 Fishing Isla  |                              |  |                                   |                        | er Fa                                   |                            |                            |                                      |                 | Sor                  | nerset                  |                                |            |
|   | neral<br>ector  |                  | 5. Social Security Number 6. S<br>218-16-5095                          | ex /.<br>[X]M 2□F            | Age (in yrs.                                 | last birthday)<br>Yrs.            | Month                  |   | Hours                      | Min.                       | B. Date of Bi<br>(Month, D<br>Dec. 2 | av. Ye.         | 922                  | Mary                    | place (State<br>intry)<br>Land | or Foreign |
|   |   |                  | Usual Residence of Decedent  |                              |  |                                   |                        |   |                            |                            |                                      | -,-             |                      | 1                       |                                |            |
| ırylan  | E O   | _                | 10a. State 10b. County   |                              | 10c. Cit                                     | ty, Town or Lo                    | cation                 |   |                            |                            |                                      |                 |                      |                         | 10d. Inside C                  | -          |
| 7 m   | all line  | ecto             | Maryland Somerse   | t                            | U  | pper Fa                           |                        |   |                            |                            |                                      |                 |                      |                         |                                | 2 X No     |
| With I  | No.   | Funeral Director | 10e. Street and Number<br>8447 Fishing Isla                            | and Pond                     |  |                                   |                        | ip Code                                 |                            |                            |                                      | 10g.            |                      | of What Cou             | intry?                         |            |
| Jeeth   |   | era              | 11. Marital Status   | 12. Was Decede               | ent Ever in U                                | l.S.   13. \                      |                        | 21867<br>edent of Hi                    | spanic Ori                 | gin? (Spe                  | cify Yes or N<br>Rican, etc.)        | 0-              | US<br>14. F          |                         | ican Indian,                   |            |
| after   | E E   |                  | 1 ☐ Never Married 2 ☐ Married  | Armed Force                  |  |                                   |                        | ecify Cuba<br>2⊠ No                     |                            | i, Puerto I                | Rican, etc.)                         |                 |                      | lack, White             | , etc.                         |            |
| nours af  | E   | d by             | 3 X Widowed 4 ☐ Divorced   | If Yes, Give<br>Year or Date | es:  |                                   | Tes                    | 2 <u>X</u> 1 NO                         | Specify:                   |                            |                                      | ,               | Spe                  | W                       | hite                           |            |
| 721   | natice  | Completed        | 15. Decedent's E<br>(Specify only highest gr                           | ducation<br>ade completed)   |  | 16a. Deced                        | kind of v              | ual Occupa<br>ork done d<br>use retired | luring most                | t of workir                | ng                                   | 16b             | . Kind of            | Business/I              | ndustry                        |            |
| within 600  |   | d mc             | Elementary/Secondary (0-12)  | College (1-4                 | or 5+)                                       | Truck                             |                        |   | /                          |                            |                                      | Lo              | ng I                 | )istar                  | ice Hai                        | ıling      |
| Hyg   | ent,  | 0                | 17. Father's Name (First, Middle, Last                                 | )                            |  | Truck                             | DLI                    | VCI                                     | 18. Mothe                  | r's Name                   | (First, Middle                       | ·               |                      |                         |                                | 8          |
| uld be file   | tic e   | To B             | Marvin Gladden   |                              |  |                                   |                        |   | Agne                       | es Co                      | x                                    |                 |                      |                         |                                |            |
| 2 sho   | = ₹   | 1 13             | 19a. Informant's Name/Relationship (                                   | **                           |  |                                   |                        |   |                            |                            | l Route Numb                         |                 |                      |                         | ip Code)                       |            |
| and teelth  | ther t  | ľ                | Marion M. Gladder  20a. Method of Disposition                          | Jr./So                       |  | 1933                              | Pine                   | way,                                    | Salis                      |                            | , Mary                               |                 |                      |                         | Town, State                    |            |
| Darkimore, Marylaria Z.Z.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. | = 6<br>= 6  |                  | 1 XBurial 2 ☐ Cremation 3 [  |                              | ater   | Place of Dispo                    |                        |   | - 1                        |                            |                                      |                 |                      |                         |                                |            |
| altimo  | in lury   |                  | 4 □ Donation 5 □ Other (Speci<br>21. Signature of F neral Service Lice | $\rightarrow$                | Spri   | inghill<br>22                     | . Name                 | and Addres                              | s of Facilit               | hv                         |                                      |                 |                      |                         | yland                          |            |
|   | eny ir  | 1                | Reversed t   | 2 sell                       | ler  | Ze<br>12                          | 11er                   | Fune                                    | ral H                      | lome,                      | P. O.<br>Road,                       | Bo              | $\frac{3}{1}$        | 171                     | س 219                          | 12         |
| Ë   |   | (                | 23a. Part1. Enter the disease, or com                                  | plications that cau          | ised the deat                                | th. Do not ent                    | er the m               | de of dyin                              | g, such as                 | cardiac o                  | r respiratory                        | arrest,         | .100                 | <u> </u>                | Approxima<br>Interval Be       | ite        |
| Phys  | ician   |                  | Immediate Cause (Final disease or condition                            | A.C                          | CVD  |                                   |                        |   |                            |                            |                                      |                 |                      |                         | Onset and                      |            |
|   | dical<br>niner  |                  | resulting in death)  | Due to (or                   | as a consec                                  | quence of):                       |                        |   |                            |                            |                                      | -               |                      |                         |                                |            |
| _ Au  | ď.  | 7                | Sequentially list conditions,  | b. Due to (or                | as a consec                                  | neuce of):                        |                        |   |                            |                            |                                      |                 |                      |                         |                                |            |
| nted  | insit   | Examiner         | if any, leading to immediate   | 200 10 (0.                   | 20 2 0000                                    | , 20.100 0.7.                     |                        |   |                            |                            |                                      |                 |                      |                         |                                |            |
| o exec  | an and<br>rial-tra                                      | Еха              | that initiated events<br>resulting in death) Last                      | C. Due to (or                | as a consec                                  | quence of):                       |                        |   |                            |                            |                                      |                 |                      |                         |                                |            |
| .O. BOX 06/00,<br>the death certificate be executed   | physicien and<br>s the burial-transit                   | dical            |  | d                            |  |                                   |                        |   |                            |                            |                                      | _               |                      | _                       |                                |            |
|   | ling pt<br>e as t                                       | Med              | IF FEMALE:   | 00- 11                       | ur wurser                                    |                                   |                        |   |                            |                            |                                      |                 |                      |                         |                                |            |
| DOX   | attending p   | Physician/Me     | 23b. Was decedent pregnant in the past 12 months?                      |                              | me of pregn<br>h 2 ⊟ Feta<br>nt at time of o | al death 3                        | Ectopic Other          | pregnancy                               |                            |                            |                                      |                 |                      | Date of deli<br>Month   | very<br>Day                    | Year       |
| j 🖁   | y the   | ysic             | 1 ☐ Yes V2 ☐ No<br>9 ☐ Unknown   | 9 Unknow                     |  | 10a(ii 5                          | JOHNE                  | ъреспу)                                 |                            |                            |                                      |                 |                      |                         |                                |            |
| L ĕ   | been signed by the should be detached                   | by Pt            | Part II. Other significant conditions                                  | contributing to dea          | th but not res                               | sulting in the u                  | nderlying              | cause give                              | en in Part I.              |                            | 23e. Did                             | tobacc          | o use c              | ontribute to            | the cause of                   | death?     |
| ecords,   | gis ue<br>d plnd  | ed b             | COPD.  |                              |  |                                   |                        |   |                            |                            | 1 🗆                                  | Yes             | 2 🗆 No               | 3 Pro                   | obabły 4 🗆                     | ]Unknown   |
| law re  | es be<br>2 sho  | Completed        |  |                              |  |                                   |                        |   |                            |                            | 24a. Wa                              | s an            | 24                   | b. Were aut             | topsy findings<br>ompletion of | available  |
| <b>E</b> &  | page<br>page  | Con              |  |                              |  |                                   |                        |   |                            |                            | perf                                 | ormed           | ?                    | death?<br>1 ☐ Yes       | . /                            |            |
| VITAI<br>iclan: 1   | certificate has t<br>irector, page 2 s                  | Be               | 25. Was case referred to medical examiner?                             | Hospital:                    |  |                                   |                        | Oth.                                    | 200                        |                            | (Check only                          |                 |                      |                         |                                |            |
| P Ay  | rthis<br>raldir   | 5                | 1 Yes 2 No   | 1 🗆 Int                      |  | 28b. Time of                      |                        |   | 4 🗆 NU                     |                            | ne Seribe                            |                 |                      |                         | ufy)                           |            |
| nding th  | : Afte  | tion             | Natural 5 Pending 2 Accident investigation                             | 28a. Date of (Month,         | Day Year)                                    | Injury                            | м                      | 28c. Injury<br>Work                     | k?<br>Yes 2 🗍              |                            |                                      |                 | .,,                  |                         |                                |            |
| DIVISION I or Attending efter death.  | rector: After this certific<br>by the funeral director, | Certification:   | 3 Suicide 6 Could not I  | 286. Place o                 | f Injury - At h                              | nome, farm, str                   | eet, fact              | ory, office                             |                            | - 2                        | 28f. Location<br>City or To          | (Street         | and Nu               | mber or Ru              | ral Route Nu                   | nber,      |
| is is is  | ed to   | Cer              |  |                              |  |                                   |                        |   |                            |                            |                                      |                 |                      |                         |                                |            |
| DIVISION OF VICE To the Hospital or Attending Physician: within 24 hours efter death.   | To the Funerel Dir<br>completely filled in              | Medical          | 29a. Certifier Certifying P (Check only 2 Medical Exe                  | hysician: To the b           | is of examina                                | owledge, deatl<br>ation and/or in | n occurre<br>vestigati | d at the tim<br>on, in my o             | ne, date an<br>pinion, dea | id place, a<br>ith occurre | and due to the<br>ed at the time     | cause<br>, date | e(s) and<br>and plac | manner as<br>e, and due | stated.<br>to the cause        | s)         |
| o the   | o the   | Med              | 29b. Signature and title of certifier                                  | and manne                    | r stated.                                    |                                   | 2                      | gc. License                             | number                     |                            |                                      | 29d.            | Date sig             | ned (Month              | , Day, Year)                   |            |
| FS  | ⊢ŏ  |                  | MICH   | 9.                           |  |                                   |                        | 00                                      | 631                        | 99                         | 4                                    | J               | me                   | 2, 20                   | 1 200                          | 06         |
|   |   |                  | 30. Name and address of person who                                     |                              |  | m 23a) (Type,                     | Print)                 |   |                            |                            |                                      |                 |                      | ,                       |                                | ,          |
|   |   |                  |  |                              | VOHL   | 1. 614                            | EA                     | STER                                    | N St                       | JORE                       | DR,                                  | SA              | LUSE                 | BURY,                   | MD,                            | 21804      |
|   | Sta<br>Regist   | ate              | 31. Date filed (Month, Day, Year)                                      | 2006 32. B                   | gistrar's Sign                               | ature                             |                        | •                                       |                            |                            |                                      |                 |                      |                         |                                |            |

|            |   |                 | 1- For State Registrar  | State of Maryl                                       |                       | partment of I  |  |  | ene           | 06                            | 22598                           |
|------------|---|-----------------|---|--|-----------------------|--|--|--|---------------|-------------------------------|---------------------------------|
|            | Planatat  |                 | Decedent's Name (First, Middle, Las   | t)   |                       |  |  | 2. Date of Death<br>Month  |               | Year                          | 3. Time of Death                |
|            | Physici<br>/Medio   |                 | Robert, We  |  | raham                 |  | sley Robert                                | 07   | 04            | 2006                          | 1615 M                          |
|            | Examir  | er              | 4a. Facility Name (If not institution, give   | street and number)                                   | Center                |  | or Location of Death                       | h  | 4c. Count     | y of Death                    |                                 |
|            | Funeral   | 7               | 5. Social Security Number 6. S  | 7. Age (In   | yrs. last birthda     | y) If Under 1 Year   | If Under 24 Hrs.                           |  |               | 9. Birthpl                    | ace (State or Foreign           |
|            | Director  |                 | 214-34-0333 2   | ØM 2□F 7   | D Yrs.                | Months Days  | Hours Min.                                 | JUN, 22  |               | Count                         | try)                            |
|            | and   |                 | Usual Residence of Decedent  10a. State 10b. County   | 10c  | . City, Town or       | Location   |  |  |               | 10                            | Od. Inside City Limits          |
|            | Many<br>I sho   | ţ               | <br>  Maryland   Frederic   | k Fr   | ederick               |  |  |  |               |                               | 1X Yes 2 No                     |
|            | or 28s  | lrec            | 10e. Street and Number  | 1==  |                       | 10f. Zip Code  |  | 10   | g. Citizen of | What Count                    | try?                            |
|            | death with the Maryland<br>ma 23a or 28a-f ahow<br>Linual be notified at  | ral             | 1605 Jennings Cou   |  |                       | 21702  |  | บร   | -             |                               |                                 |
|            | item<br>item  | Funeral Directo | 11. Marital Status 1 ☐ Never Married 2 ☐ Married  | 12. Was Decedent Ever i<br>Armed Forces?             | in U.S. 1             | <ol> <li>Was Decedent of I<br/>If Yes, specify Cub</li> </ol>        | Hispanic Origin? (S<br>ean, Mexican, Puert | pecify Yes or No-<br>o Rican, etc.)  |               | ce - America<br>ick, White, e |                                 |
| 200        | e filed within 72 hours after death with the Marylan<br>il Hygiene Library of theme 23a or 28a-1 ahow<br>other then "natural", or frame 23a or 28a-1 ahow<br>vent, ire Medical Examinar inter the collisid at | ğ               | 3 □Widowed 4 🕅 Divorced   | 1 X Yes 2 □ No<br>If Yes, Give<br>Year or Dates: 195 | 7-60                  | 1 ☐ Yes 2 🕅 No   | Specify:                                   |  | Specia        | y:<br>Whi                     | te                              |
| 21215-0036 | 72 hc   | Completed       | 15. Decedent's Ed<br>(Specify only highest gra-   |  | 16a. De               | pedent's Usual Occup<br>we kind of work done<br>on DO NOT use retire | pation<br>during most of wor               | king   | 6b. Kind of B |                               |                                 |
| 7          | within<br>ene.<br>then  | Idmo            | Elementary/Secondary (0-12)   | College (1-4or 5+)                                   |                       | . DO NOT use retire<br>t Metal O                                     | •  | 1  | DC D4         | ad 4 a 1                      | Creations                       |
| 2          | illed<br>Hygi<br>other  | BeCc            | 17. Father's Name (First, Middle, Last)   |  | bilee                 | t Hetal O  | <del>^</del>                               | ne (First, Middle, M.  |               |                               | Systems                         |
| /a         | should be<br>ind Menta<br>i marked<br>umatic ev   | To 8            | Robert Heaton Gral  | nam  |                       |  | Lucille                                    | Goldie Ma  | nn            |                               |                                 |
| Maryland   | 2 sho<br>and<br>is ma   |                 | 19a. Informant's Name/Relationship (7   |  |                       | iling Address (Street  |  |  |               |                               |                                 |
| _          | s 1 and<br>f Heelth<br>item 27<br>other t   |                 | Kimberly Horn, dat  |  | b. Place of Dis       | 7 Scarlet position (Name of  |  | The same of the sa | mantov        |                               |                                 |
| Baltimore, | 8°= 5   |                 | 1 Burial 2 ACremation 3 4 Donation 5 Other (Specify   | Removal from State                                   | cemetery, c           | rematory or other pla  | 1  |  |               | •                             |                                 |
|            | permit. Pag<br>Depertment<br>Importent:<br>any injury once  |                 | 21. Signature of Funeral Service Licen  |  | MILCHS D              | irg Cremat<br>22. Name and Addre                                     | ess of Facility Ke                         | enev and   | Racfo         | ourg, .                       | Maryland<br>meral Home          |
| n          | 88 58   |                 | Kyan de 3   | Dein M   | JU999 L               | Ub East C  | hurch Str                                  | eet, Fred  | lerick        | , Mary                        | land 21701                      |
|            |   |                 | 23a. Part1. Inter the disease, or compositions, or her it failure. List only of                             | ications that caused the cone cause on each line.    | leath. Do not e       | inter the mode of dyi  | ng, such as cardiac                        | or respiratory arres   | st,           |                               | Approximate<br>Interval Between |
|            | Physician<br>/Medical   |                 | Immediate Cause (Final disease or condition resulting in death)   | a anoxio   |                       | ain in   | Jury                                       |  |               |                               | Onset and Death                 |
|            | Examiner  |                 |   | Due to (or as a con                                  | . /                   | fall wi  | th head                                    | 1 traum  | a             |                               | 5 1                             |
|            |   | Jer             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a con                                  |                       | (30)11 00  |  | 1  | 1             |                               | - Hays                          |
| 2          | acuted<br>and<br>transi   | Examiner        | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last                               | c. Cardia  |                       | rest   |  | 1.   | MER           | 1                             | 5 days                          |
| 8/60,      | cate be executed<br>bhysicien and<br>the burial-transit   | al E            | rooding in South, cast  | Due to (or as a con                                  | sequence of):         |  | 0  | - West   | ch.           |                               |                                 |
| 289        | death certificate be executed<br>e attending physicien and<br>id for use as the burial-transit  | edical          |   | d  |                       |  | 4  | OVED BY  |               |                               |                                 |
| XOR        | eath certific<br>attending p  | clan/Me         | 200. Has decedent program   | 23c. If yes, outcome of pre<br>1 ☐ Live birth 2 ☐ F  |                       | B Ectopic pregnanc   | OFFILERA                                   | ON APP.  | 23d. Da       | te of deliver                 | •                               |
|            | at the dea<br>by the att  | sici            | in the past 12 months?<br>1 □ Yes 2 □ No<br>9 □ Unknown   | 4☐Pregnant at time<br>9☐Unknown                      |                       | Other (specify)  | CENTIFIC                                   |  | Mo            | onth C                        | Day Year                        |
| 7          | res that thisigned by   | / Physi         | Part II. Other significant conditions co  | ontributing to death but not                         | resulting in the      | underlying cause giv   | ven in Part I.                             | 23e. Did toba  | cco use con   | tribute to the                | cause of death?                 |
| S          | quires<br>n sign  | ed by           |   |  |                       |  |  | 11111  | 2 🗆 No        |                               | bly 4 ∐Unknown                  |
| ecords,    | The law requires that<br>ste hes been signed b<br>page 2 should be dete   | Completed       |   |  |                       |  |  | 24a. Was an  | 24b.          | Were autop:                   | sy findings available           |
| r          |   | Com             |   |  |                       |  |  | autopsy performe   | ed?           | death?                        | pletion of cause of             |
| Vita       | sician:<br>certific<br>rector,  | Be              | 25. Was case referred to medical examiner?  | Hospital:  |                       | . 0#   |  | th (Check only one)  |               |                               |                                 |
| 5          | Attending Physician: r death. ector: After this certific by the funeral director.   | . To            | 1 Yes 2 No<br>27. Manner of Death   | 28a. Date of Injury                                  | 28b. Time             | GIL 30 DOA   |  | ome 5 Residen  |               |                               |                                 |
| <u>0</u>   | uttending<br>death.<br>ctor: Aft<br>y the fun   | atlon:          | 1 □Natural 5 □ Pending 2 ■Accident investigation  | JUN, 30, 20  |                       |  | rk?<br> Yes 2 No                           | Fall while   | e climb       | sing to                       | o balconey                      |
| DIVISION   | i or Atte<br>after de<br>Directo  | Certificati     | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Injury - A<br>building, etc. (Sp       | At home, farm, ecify) |  | derick, MD                                 | 28f. Location (Stre  | et and Numb   | Per or Rural                  |                                 |
| _          | Hospital or<br>24 hours afte<br>Funeral Dire<br>stely filled in t   |                 | 29a. Certifier 1 Certifying Phy   | Friends Apt  |                       |  | Apt Cz                                     | picuse se  | C 286         | Fred                          | erick Md.                       |
|            | To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by  | edical          | (Check only 2 Medical Example one)  | iner: On the basis of exame and manner stated.       | nination and/or       | investigation, in my o   | opinion, death occur                       | red at the time, date  | e and place,  | and due to t                  | ted.<br>he cause(s)             |
|            | To the Ho<br>within 24 I<br>To the Fu<br>completely   | M               | 29b. Signature and title of certifier   | 2  |                       | 29c. Licens  | e number                                   | 290  | I. Date signe | d (Month, D                   | ay, Year)                       |
|            | 10  |                 | 1///  |  |                       |  | 60292                                      |  | 1/-1          | 04                            |                                 |
|            | 0   |                 | 30. Name and address of person who o  | ompleted cause of death (                            |                       | e, Print)  | Sx B                                       | Himore   | MI            | 7 212                         | 224                             |
|            | Sta   |                 | 31. Date filed (Month, Day, Year) -   | 32. Registrar's Si                                   |                       | -1-  | '/(  | 7  |               |                               | //                              |
| P          | Registr   |                 | JUL 157   | 2006 Color   | · K.                  | Coale  |  |  |               |                               |                                 |
| DH         | MH 17 Rev 1/2   | JUI             |   | ***  |                       | •  |  |  |               |                               |                                 |

DHMH 17 Rev 1/2001

|   |                  | State of Maryland / Dep  | ertment of Health and Mertificate of Death   |   | ene<br>No 2006                                  | 22599  |
|---|------------------|--|--|---|---|--|
| Physici   | an               | 1. Decedent's Name (First, Middle, Last)  Mary Louise Humphreys  |  | 2. Date of Death<br>Month<br>June 28                        | Day Year  | 3. Time of Death 12:11 PM                            |
| /Medic<br>Examin  |                  | 4a. Facility Name (If not institution, give street and number)  Calvert Memorial Hospital  | 4b. City, Town, or Location of Death<br>Prince Frederick   | Durie 20  | 4c. County of Death<br>Calvert                  |  |
| Funeral<br>Director   |                  | 5. Social Security Number 214-26-5933 6. Sex 1 □ M 2 □ F 7. Age (In yrs. last birthda) 78 Yrs.   | Months Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Y<br>April 17              | (ear) Cou                                       | place (State or Foreign<br>intry)<br>yland           |
| Aaryland<br>f show  | ō                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I  Maryland Calvert Broomes 3   |  |   |   | 10d. Inside City Limits 1 ☐ Yes 2 No                 |
| with the A<br>3s or 28e-  | Funeral Director | 10e. Street and Number<br>4030 Nans Cove Road  | 10f. Zip Code<br>20615   |   | Citizen of What Counited Stat                   |  |
| istryisting AIAINONONONONONONONONONONONONONONONONONO  | by Funera        | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:   | Was Decedent of Hispanic Origin? (Sp<br>If Yes, specify Cuban, Mexican, Puerto<br>1  Yes 2 No Specify: | ecify Yes or No-<br>Rican, etc.)                            | 14. Race - Amer<br>Black, White<br>Specify: whi | , etc.   |
| d within 72 hours aff<br>giene.<br>er than "natural", or<br>the Wedeal Exam   | Completed b      | 15. Decedent's Education (Giver any highest grade completed)   | edent's Usual Occupation<br>re kind of work done during most of work<br>DO NOT use retired)            | sing 16   | b. Kind of Business/li                          | ndustry  |
| filed<br>Hygi<br>other  | Be               |  | carrier  18. Mother's Nam  Lorena  | e (First, Middle, Ma  | ost Office<br>iden Sumame)                      | 2  |
| Incl ylalla.  | To               |  | iling Address (Street and Number or Rui<br>Nans Cove Rd. Bro   |   |   |  |
| baltimore, Marylar prair permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury or other traumetic evonce. |                  | 20a. Method of Disposition  20b. Place of Discompton, 3 Removal from State   | amatani or other place)  | 006   | oc. Location - City or T                        |  |
| permit. Departm Importa any inju  |                  | DRause 4   | 22. Name and Address of Facility  405 Broomes Is. Rd   | . Port Re   | uneral Hon<br>public MD                         | 20676  |
| Physician   |                  | 23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. FOBASE FU |  | 30CL  | t,  | Approximate<br>Interval Between<br>Onset and Death   |
| /Medical<br>Examiner  | er               | Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):                                  | DVT  |   |   | 4 days   |
| <b>68 / 60,</b> ifficate be executed g physician and as the burial-transit  | Ical Examiner    | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c. SHING LES  Due to (or as a consequence of):  | > ARTHRITIS  |   |   |  |
| death certifi<br>death certifi<br>e attending<br>ed for use as  | Physician/Medic  | IF FEMALE: 23c. If yes, outcome of pregnancy   1   | 3□Ectopic pregnancy 5 □ Other (specify)  |   | 23d. Date of deli<br>Month                      | very<br>Day Year                                     |
| S, P.   | by               | 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the  | underlying cause given in Part I.  | 23e, Did toba   | icco use contribute to                          | the cause of death?                                  |
| HeC<br>he law<br>e has t<br>age 2 s   | Completed        |  |  | 24a. Was an autopsy performs                                | prior to death?                                 | topsy findings available completion of cause of 2 No |
| Of VITA Physician: r this certific and director,  | To Be            | 25. Was case referred to medical examiner?  1 Yes 2 No  27. Manney of Death  1 Tallowed 5 Deading (Month, Day Year)  | ient 3 DOA Other: 4 Nursing H  | th (Check only one)<br>ome 5 - Residen<br>28d. Describe how | ice 6 Other (Spec                               | cify)  |
| Vittan<br>deat<br>ctor:<br>y the  | Certification:   | 1  | M 1 Yes 2 No   | 28f. Location (Stre<br>City or Town,                        | eet and Number or Ru<br>State)                  | iral Route Number,                                   |
| Hospitel<br>14 hours a<br>Funaral I<br>tely filled  | edical Ce        | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.                                     | eath occurred at the time, date and place<br>investigation, in my opinion, death occu                  | , and due to the cau<br>irred at the time, dat              | use(s) and manner as<br>te and place, and due   | stated.<br>to the cause(s)                           |
| To the within 2 To tha comple   | Me               | 29b. Signature and title of certifier  Which was a signature and title of certifier  MD  | 29c. License number  DOOGOGT   |   | d. Date signed (Mont) 6/28/0                    | *              |
| 10  |                  | 30. Name and address of person who completed ause of death (Item 23a) (Tylicon to the COAD, PRINCE   | FREDERICK  | MD 2  | 0678  |  |
| S<br>Regis  | tate<br>trar     | 31. Date filed (Month, Day, Year)  JUL 0 5 2006  Message Signature   | . Sparli   |   |   |  |

State of Maryland / Department of Health and Mental Hygiene UUb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Rita Arlene Hughes June 20, 2006 1:58 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 52 Yrs Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ XF 279-54-1478 Director June 26, 1953 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or iteme 23s or 28e-f ehow the Medical Examiner must be motified at 1 Yes 2 TrNo Directo Maryland Prince Georges Laurel 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 14200 Laurel Park Drive 20707 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Indian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No δ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 mit. Pages 1 and 2 should be filed w perment of Health and Mental Hygier portant: If tem 27 is marked other th y njury or puher traumatic event, in Dietician Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Dean Barbara Dean McDougal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Coleman 12261 Pendercreek Circle, Fairfax, VA 22033 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 07-03-06 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Fort Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Huneral Service Licensee 22. Name and Address of Facility Simple Tribute, 1040 Rockville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** year Liver Cell Failure /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cirrhosis of the Liver years attending physicien and for use as the burial-transit Attending Physician: The law requires that the death certificate be executed Hepatitis B 5 years Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificete has been sign rector, page 2 should be Hypertension 3 Probably 4 ∰Unknown 1 ☐ Yes 2 ☐ No Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 √ No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 28a. Date of Injury (Month, Day Year) Medical Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 5 within 24 hours e To the Funeral I completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the dawle(s) and manner as stated 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053615 June 22, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aruna S. Nathan, M.D. 11125 Rockville Pike, Suite 208, Rockville, MD 20852

State

Registrar

31. Date filed (Month, Day, Year)

0

32. Registrar's Signature

19.186

2006

03

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MAURICE HASKINS JUNE 27 2006 3:05 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4619 PENDALL DRIVE FT. WASHINGTON PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Yrs. Director 229-36-2095 1934 VIRGINIA Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examinar must be notified at 1X Yes 2 No Director PRINCE GEORGE'S FT. WASHINGTON 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20744 U.S.A. 4619 PENDALL DRIVE by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 X Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC PRIVATE 9TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Heelth and Mental ant: if Item 27 is marked o THOMAS HASKINS LILLIAN HARRIS ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GWENDOLYN DENT/DAUGHTER 4619 PENDALL DRIVE FT. WASHINGTON, MARYLAND 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY July 3, 2006 LANDOVER, MARYLAND 21. Signature of Juneral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG CANCER resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine requires that the death certificate be executed ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificete 1 ☐ Yes 1 Yes 2**₹** No 2K No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 2 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 X Natural s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital o within 24 hours aff To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0039691 JUNE 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. REDJAEE M.D. 4467 OLD BRANCH AVENUE # 201 TEMPLE HILLS, MARYLAND 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUL 0 3 2006 Registrar

|                   |   | -              | For State Registrar  | State of Maryla   | •                           | artment of H<br>tificate of I                                   |  |                                    | ene 2006                             | 22602  |
|-------------------|---|----------------|--|---|-----------------------------|---|--|------------------------------------|--------------------------------------|--|
|                   | Physicia  | an             | 1. Decedent's Name (First, Middle, Last)  James A. Harli   | ng. Sr.   |                             |   |  | 2. Date of Death<br>Month<br>June  | Day Year 28 2006                     | 3. Time of Death 7:03 A                            |
| )                 | /Medic<br>Examin  |                | 4a. Facility Name (If not institution, give s  |   |                             | 4b. City, Town, or  | Location of Death                          |                                    | 4c. County of Death                  |  |
|                   | Funeral   |                | Southern Mary1a 5. Social Security Number 6. Sex   | 7. Age (In y  | rs. last birthday)          |   | Clinton  If Under 24 Hrs.  Hours Min.      | 8. Date of Birth<br>(Month, Day,   | Year) 9. Birth                       | George's   |
|                   | Director  | -              | 213-40-8885  Usual Residence of Decedent  10a. State 10b. County   | 62  | City, Town or Lo            | cation  |  | Nov. 7,                            | 1943   Sout                          | th Carolina  10d. Inside City Limits               |
|                   | Maryla<br>I-f ehov  | to             | Maryland Prince Ge   |   | City, Town of Lo            |   | ple Hills                                  | 3                                  |                                      | 1 X Yes 2 No                                       |
|                   | with the<br>a or 284<br>be not  | Dire           | 10e. Street and Number 3104 Be11broc   |   |                             | 10f. Zip Code   | 20748                                      |                                    | Og. Citizen of What Co               |  |
| 36                | ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at   | by Funeral     |  | 2. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☐ XNo If Yes, Give                       | 1                           | Was Decedent of H<br>f Yes, specify Cuba<br>1 ☐ Yes 2 XNo       | ispanic Origin? (Sp<br>an, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)   | United  14. Race - Amer Black, White | ican Indian,                                       |
| 21215-0036        | in 72 hour<br>n "naturel"<br>hudical Ex   | Completed b    | 15. Decedent's Educ<br>(Specify only highest grade   | completed)  | (Give                       | dent's Usual Occup<br>kind of work done o<br>DO NOT use retired | during most of work                        |                                    | 6b. Kind of Business/                | ndustry  |
| d 212             | filed within<br>Hygiene.<br>other than *  | Be Com         | Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last)   | College (1-4or 5+)  | M                           | etro Tran   | sit Autho                                  | e (First, Middle, N                | Priva<br>Maiden Sumame)              | ite  |
| /lan              | uld be<br>Mental<br>rrked c   | To B           | Lonnie W.  | Harling   |                             |   |  | Carrie I                           | Lue Kemp                             |  |
| Maryland          | id 2 should<br>th and Men<br>27 ie marke<br>traumatic   |                | 19a. Informant's Name/Relationship (Type LaTrina C. Harlin   | •   |                             | •   |  |                                    | City or Town, State, Z DC 20020      | ip Code)   |
| as .              | Pages 1 and 2 and 2 and 2 and 3 and |                | 20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)                                 | 20<br>emoval from State   | -                           | matory or other plac  | e)   7/7,                                  |                                    | 20c. Location - City or T            |  |
| Baltir            | permit. Pages 1 Department of H important: If ite eny injury or ot  |                | 21. Signature of Funeral Service License   |   |                             | 2. Name and Addre   | ss of Facility                             | Stewart I                          | Funeral Homash., DC 20               | ie   |
|                   |   |                | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on   | ations that caused the d  | leath. Do not ent           |   |  |                                    |                                      | Approximate<br>Interval Between<br>Onset and Death |
|                   | Physician<br>/Medical   |                | Immediate Cause (Final disease or condition resulting in death)  | Adeno car o   | ing ma (                    | Colon with  | i metas tase                               |                                    |                                      | Onsor and Dourn                                    |
| ı                 | Examiner  | P.             | Sequentially list conditions,  | Due to (or as a con   | saquones of):               |   |  |                                    |                                      |  |
|                   | and<br>transit  | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | . Due to (or as a con   | annuana at);                |   |  |                                    |                                      |  |
| 68760,            | iticate be executed<br>physician and<br>is the burial-transit   | edical E       |  |   |                             |   |  |                                    |                                      |  |
| .O. Box 6         | law requires thet the death certitis<br>es been signed by the attending f<br>2 should be detached for use as  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                      | 3c. If yes, outcome of pre<br>1 □ Live birth 2 □ F<br>4 □ Pregnant at time<br>9 □ Unknown | etal death 3                | Ectopic pregnancy Other (specify)                               | /  |                                    | 23d. Date of deli<br>Month           | very<br>Day Year                                   |
| <u>α</u>          | w requires that is been signed by should be detailed  | þ              | Part II. Other significant conditions con  | tributing to death but not  | resulting in the u          | nderlying cause giv   | ren in Part I.                             | 23e. Did tob                       | es 2 ⊡No 3 □ Pro                     | the cause of death?                                |
| of Vital Records, | The<br>ete h<br>page  | Completed      |  |   |                             |   |  | 24a. Was an autops perform         | y prior to death?                    | topsy findings available completion of cause of    |
| Vita              | iclen:<br>certific  | Be             | 25. Was case referred to medical examiner?   | ospital:  |                             | - 20 DOA Ott  | on   | th (Check only on                  |                                      |  |
|                   |   | lon: To        | 27. Manner of Death  1 Natural 5 Pending   | ospital: 1 Inpatient :<br>28a. Date of Injury<br>(Month, Day Yea                          | 28b. Time o                 | f 28c. Injur  | y at rk?                                   |                                    | nce 6 Other (Specew injury occurred  | afy)   |
| Division          | or Attenvitter deat   | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury - /<br>building, etc. (Sp  | At home, farm, st<br>ecify) |   | Yes 2 □ No                                 | 28f. Location (St.<br>City or Town | reet and Number or Ru<br>, State)    | ral Route Number,                                  |
| _                 | To the Hospital or At within 24 hours after of To the Funeral Directormpletely filled in by   | edical Ce      |  | Acian: To the best of my<br>ner: On the basis of exam<br>and manner stated.               |                             |   |  |                                    |                                      |  |
|                   | within 2<br>To the<br>complet   | Me             | 29b. Signature and title of certified  |   |                             | 29c. Licens   | e number                                   | 2                                  | 9d. Date signed (Monti               | n, Day, Year)                                      |
|                   | (   |                | > Klahn  | m   | 9                           |   | 55120                                      |                                    | Tune 29 201                          | 96   |
| 2                 | 13  |                | 30. Name and address of person who co  | 1328 Souther  | 2 avenu                     | e SE Such   | c 310 Wah                                  | ington Do                          | 20032                                |  |
|                   | Sta<br>Regist   | ate<br>rar     | 31. Date filed (Month, Day, Year)  | 32. Registrar's S   | ignature                    | ري  |  |                                    |                                      |  |

|                   |   | •              | 1 - For Amend Item 2.  | 5 per ME, G85   | 7,07/17/                              | Obdhb<br>Cliricate of L                    | Death                    | vientai Hygi<br>Reg                     | ene 006                           | 22603  |
|-------------------|---|----------------|--|---|---------------------------------------|--|--------------------------|---|-----------------------------------|--|
| 1                 |   | , in           | Decedent's Name (First, Middle, La.  | st)   |                                       |  |                          | 2. Date of Death                        | Day V                             | 3. Time of Death                                 |
|                   | Physici<br>/Medic   |                | CLIFTON  | JASON   |                                       | HUFF                                       |                          | Month<br>June                           | Day Year 200                      | 17 00 11   |
|                   | Examin  |                | 4a. Facility Name (If not institution, give                                  |   | - 1                                   | 4b. City, Town, or                         | Location of Death        |   | 4c. County of De                  | ath  |
|                   |   |                | The John's Ho  | PKins Hos   | pital                                 | Palti                                      | nore                     |   | 1//                               | A  |
|                   | Funeral   | -              | Social Security Number 6. S  |   | yrs. last birthday)                   | If Under 1 Year                            | If Under 24 Hrs.         | 8. Date of Birth                        | <b>3</b> . B                      | irthplace (State or Foreign                      |
|                   | Director  |                | 214-04-9432  | M 2□F 35  | Yrs.                                  | Months Days                                | Hours Min.               | (Month, Day, )<br>09/14/19              | 770                               | rvland   |
|                   | p .   |                | Usual Residence of Decedent  |   |                                       |  |                          | 1 0 7 1 7 1 .                           | 770   11a                         | 1 y 1 a li u                                     |
|                   | rylar   |                | 10a. State 10b. County   | 10c   | : City, Town or Lo                    | ecation                                    |                          |   |                                   | 10d. Inside City Limits                          |
|                   | e Ma  | Director       | MD Allegan   | у   | Cum                                   | berland                                    |                          |   |                                   | 1√ Yes 2 No                                      |
|                   | h the   | ē              | 10e. Street and Number   |   |                                       | 10f. Zip Code                              |                          | 100                                     | g. Citizen of What C              | Country?   |
|                   | within 72 hours after death with the Maryland liene. I then "natural", or Iteme 23a or 28a-f show then "madical Examinat must be notified at the Medical Examinat must be notified. |                | 834 Golden   | Lane  |                                       |  | 21502                    |   | USA                               |  |
|                   | deat  | Funeral        | 11. Marital Status   | 12. Was Decedent Ever                                     |                                       | Was Decedent of Hi                         | spanic Origin? (Sc       | ecify Yes or No-                        | 14. Race - Am                     | nerican Indian,                                  |
| 9                 | after<br>or Its   |                | 1 X Never Married 2 ☐ Married  | Armed Forces? 1 ☐ Yes 2 ☑ No                              |                                       | f Yes, specify Cuba                        |                          | Rican, etc.)                            | Black, Wh                         | ite, etc.  |
| Ö                 | urs a   | δ              | 3 ☐ Widowed 4 ☐ Divorced   | If Yes, Give 22<br>Year or Dates:                         |                                       | 1 ☐ Yes 2 ☑ No                             | Specify:                 |   | Specify:                          | White  |
| 21215-0036        | 72 ho<br>natur  | Completed      | 15. Decedent's Ed  |   | 16a. Dece                             | dent's Usual Occupa                        | ation                    | . 16                                    | Sb. Kind of Busines               |  |
| 2                 | within 7<br>ene.<br>then "r   | pie            | (Specify only highest gra  | College (1-4or 5+)  | life.                                 | kind of work done of<br>DO NOT use retired | furing most of work<br>) | ung                                     |                                   |  |
| 2                 |   | ПО             | 12   | Conogo (1 401 5+)   | C                                     | hef  |                          |   | Res                               | ort  |
| ਰੂ                | be filed<br>ital Hygi<br>d other<br>event, I  | 0              | 17. Father's Name (First, Middle, Last)                                      |   |                                       | TIEL                                       | 18. Mother's Nam         | e (First, Middle, Ma                    |                                   | OLC  |
| ā                 |   | 0.0            | Robert   | Lee   | Huff                                  |  | Patrici                  | a An                                    | n                                 | Batt   |
| Maryland          | Shou<br>nd N<br>man   | -              | 19a. Informant's Name/Relationship (7  | Type, Print)  | 19b. Mailir                           | ng Address (Street a                       |                          | al Route Number, (                      |                                   |  |
| Ž                 | and 2<br>leafth a<br>m 27 is  |                | Robert L. Huff /   | father  |                                       |  |                          | erland, M                               |                                   |  |
| ē,                | - I 0 -   |                | 20a. Method of Disposition   |   | b. Place of Dispo                     | sition (Name of                            |                          |   | cary Land<br>c. Location - City o | 21502  |
| Baltimore,        | ë - = 5   |                | 1 🖾 Burial 2 🗆 Cremation 3 🗆   |   |                                       | natory or other place                      | . 1                      |   |                                   |  |
| Ħ                 | nit. Pag<br>partment<br>ortant:<br>injury d   |                | 4 □ Donation 5 □ Other (Specify 21. Signature of Fur eral Service Licen      | . 13  | unset Me                              | morial Pa                                  | rk   06/1                | 3/2006                                  | Cumberlan                         | d, MD  |
| Ba                | permit. Departm importa eny inju  |                | 21. Signature in Full et al Service Ciceri                                   | 300   | - 22                                  | . Name and Addres                          | is of Facility Ada       | ams Famil                               | y Funeral                         | Home, P.A.                                       |
| 2-                | 40-00   |                | part.  | men   |                                       |  |                          | Cumber1                                 |                                   | 21502  |
|                   |   |                | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only | dications that caused the cone cause on each line.        | death. Do not ent                     | er the mode of dying                       | g, such as cardiac       | or respiratory arrest                   | t,                                | Approximate<br>Interval Between                  |
|                   | Physician   |                | Immediate Cause (Final disease or condition                                  | Preumo  |                                       |  |                          |   |                                   | Onset and Death                                  |
|                   | /Medical  |                | resulting in death)  | Due to (or as a con                                       |                                       |  |                          |   |                                   | two weeks  |
|                   | Examiner  |                | Sequentially list conditions,  | b relapsed  | AML                                   | *-   |                          |   |                                   | ten manths                                       |
| 31                | D =   | ner            | P. now Londings to part surflates  | Dise to (or se a con                                      | eequaries of):                        |  |                          | M.                                      |                                   |  |
|                   | ficate be executed physicien and sthe burial-transit  | Examiner       | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events | c.  |                                       |  | ///                      | N APPROVED BY M                         | CAL EXAMINER                      |  |
| ó                 | icate be execut<br>physicien and<br>s the burial-trar   |                | resulting in death) Last   | Due to (or as a con                                       | sequence of);                         |  |                          | POVED BY M                              |                                   |  |
| 68760,            | ysici<br>ne bu  | dicai          |  | d   |                                       |  | TIEICATIO                | MAPPRO                                  |                                   |  |
| _                 | tifica<br>ng ph<br>as th  | (1) (1)        |  |   |                                       |  | CEKIII                   | - 10                                    |                                   |  |
| Вох               | h certii<br>anding<br>use a   | 2              | IF FEMALE:<br>23b. Was decedent pregnant                                     | 23c. If yes, outcome of pre                               |                                       |  |                          |   | 23d. Date of de                   | alivery  |
| m<br>m            | death<br>e atten  | icia           | in the past 12 months?   | 1 ☐ Live birth 2 ☐ F<br>4 ☐ Pregnant at time              |                                       | Ectopic pregnancy Other (specify)          |                          |   | Month                             | Day Year   |
| P.O.              | that the death certified by the attending detached for use a  | Physician/M    | 9 🗆 Unknown  | 9Li Unknown   |                                       |  |                          |   |                                   |  |
|                   | law requires that the as been signed by the 2 should be detache   | by P           | Part II. Other significant conditions of                                     | ontributing to death but not                              | resulting in the ur                   | iderlying cause give                       | n in Part I.             | 23e. Did tobac                          | co use contribute t               | o the cause of death?                            |
| of Vital Records, | quire<br>n sig  | D D            | Acute Renal Failu  | re from faci  | alimus +                              | raicity                                    |                          | 1 ☐ Yes                                 | 2 □ No 3 □ P                      | robably 4. Unknown                               |
| 00                | w require   | lete           |  |   |                                       |  |                          | 24a. Was an                             | 245 146                           |  |
| He                | has<br>ge 2   | Completed      |  |   |                                       |  |                          | autopsy<br>performe                     | d? vvere a prior to death?        | utopsy findings available completion of cause of |
| g                 | ding Physician: The h. h. After this certificate ha funeral director, page  |                |  | ***   |                                       |  |                          |   |                                   | s 2.85 No  |
| =                 | certi   | Be             | 25. Was case referred to medical examiner?                                   | Hospital:   |                                       | Ottoo                                      |                          | Check only one                          |                                   |  |
| ō                 | Phys<br>this<br>aldi  | 2              | Yes 25 No.   | 1 Alinpatient 2   | 2 ER/Outpatien                        |  | 4 LI Nursing Ho          | me 5 Residenc                           |                                   | ecify)   |
| 2                 | ling<br>After<br>fune   | 0              | 1 Matural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year                   | 28b. Time of<br>Injury                | 28c. Injury<br>Work                        | ?                        | 28d. Describe how                       | injury occurred                   |  |
| S                 | tend<br>death<br>tor:<br>the  | cat            | 2 Accident investigation 3 Suicide 6 Could not be                            |   |                                       |  | es 2 □ No                |   |                                   |  |
| Division          | or Al<br>fter<br>Direc  | Certification: | 4 Homicide determined  | 28e. Place of Injury - A building, etc. (Sp.              | At home, farm, stre<br>ec <i>ify)</i> | eet, factory, office                       |                          | 28f. Location (Stree<br>City or Town, S | et and Number or R.<br>State)     | ural Route Number,                               |
| _1                | urs a   |                |  | 4   |                                       |  |                          |   |                                   |  |
|                   | S O U   | edical         | Check only 2   Medical Exam  | ysician: To the best of my<br>liner: On the basis of exam | knowledge, death                      | occurred at the time                       | e, date and place,       | and due to the caus                     | se(s) and manner as               | s stated.  |
|                   | 동수를 등   | 77             | one)   | and manner stated.  |                                       |  |                          | -                                       |                                   |  |
|                   | the Ho<br>hin 24 h<br>the Fu  | Nec            | Ant Alman IIII   |   |                                       | 29c. License                               | number                   | 29d.                                    | Date signed (Mont                 |  |
|                   | To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page    | Med            | 29b. Signature and title of centrier   | 110   |                                       |  |                          |   | Date dignes (mont                 | th. Day, Year)                                   |
|                   | To the Ho within 24 h To the Fu completely  | Med            | 29b. Signature and title of confiner   | MD  |                                       | RES  | -000                     |   | ine 8, 200                        |  |
|                   |   | Mec            | 30. Name and address of person who of  | completed cause of death (                                |                                       | Print)                                     |                          | 5.                                      | ine 8,200                         | >6   |
|                   |   | Mec            | 30. Name and address of person who of  | completed cause of death (                                |                                       | Print)                                     |                          | 5.                                      | ine 8,200                         | >6   |
|                   | 2   | ₹              | Malald   | completed cause of death (                                |                                       | Print)                                     |                          | 5.                                      | ine 8,200                         | >6   |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 11:15 A M Edward C. Hudson TWI 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Dorchester Dorchester General Hospital Gambriuge If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Nov. 28, Cambridge 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1915 Maryland 213-18-5363 Yrs 90 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No East New Market Maryland Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21631 USA 1922 Academy St., Apt. 204 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ₩Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Automobile and Elementary/Secondary (0-12) College (1-4or 5+) Transportation Sales 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Marjorie Ann Conquest Arthur Hudson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marjorie A. Reeves/Daughter 1427 Bay Head Rd., Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State MidShoreCremationCenter 7/2/2006 Cambridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 23a Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart latiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hea Congestive disease or condition resulting in death) Due to (or a consequence of) ischemic casdio Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

The law requires that the death certificate be executed

attending

use

ō

signed by the at d be detached for

page 2 should

Be

2

Certification:

Medical

iter death. irector: After this certifical in by the funeral director, p or Attending Physicien:

in by

within 24 hours a

To the Funerel C

completely filled i filled

0

Division of Vital Records, P.O. Box 68760,

**Physician** 

**Examiner** 

Director

Be

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury or other treumatic event, the Medical Examiner must be notified at 2028.

Baltimore, Maryland 21215-0036

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physician and s the burial-transit that initiated events resulting in death) Last Completed by Physician/Medical as the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

26. Place of Death (Check only one)

1 Yes 2 No 3 TProbably 4 ☐Unknown

24a. Was an autopsy performe 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

| 25 | Was case examiner? |       | to | medica |
|----|--------------------|-------|----|--------|
|    | 1 Tyes             |       |    |        |
| 07 | Mannar of          | Dooth |    |        |

5 Pending investigation

6 Could not be

determined

Hospital: 28a. Date of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 Accident

3 🗌 Suicide

4 Homicide

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier M.D 29c. License number DS0804 29d. Date signed (Month, Day, Year) July 1, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Malkue, M.D

408 B Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Cambridge, MD 21613

State Registrar o 3 2006



|                     |   |                   | i icasc i  | State of Marylar   |   |                                   |                           |                 | Mental Hy                               | •   |                                       | 2200   | E    |  |
|---------------------|---|-------------------|--|--|---|-----------------------------------|---------------------------|-----------------|---|---|---------------------------------------|--|------|--|
|                     |   | •                 | 1 - For<br>State<br>Registrar  | Otato or maryta.   |   |                                   | te of De                  |                 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Reg. No.  | 100                                   | 2260   | C    |  |
|                     | *   |                   | 1. Decedent's Name (First, Middle, Last)   |  |   |                                   |                           |                 | 2. Date of De<br>Month                  | eath<br>Day   | Year                                  | 3. Time of Dea                                     | th   |  |
|                     | Physicia<br>/Medic  | al                |  | J. Huttman -   | · Daye  |                                   |                           |                 | 07                                      | 01  | 2006                                  | 1010 F   | М    |  |
| j                   | Examin  |                   | 4a. Facility Name (If not institution, give  |  |   | 4b. Cit                           | _ 41                      | cation of Dear  | th                                      |   | nty of Death                          |  | 110  |  |
|                     | 7.  | $\mathcal{H}^{g}$ | University of Mary   | and Medical Ce   | ater  | lf I lad                          | Balting<br>or 1 Year   If | Under 24 Hrs    | yland                                   | 50  | Himon                                 | City N   | 17   |  |
| 4                   | Funeral<br>Director   |                   | 5. Social Security Number 6. Security Number 1233-62-2633  | 7. Age (In yrs.  | . rast birthday,<br>67 Yrs.   | Month                             |                           | Hours Min       |   | πη<br>ay, Year)<br>2 1020                               |                                       | lace (State or For                                 |      |  |
|                     |   |                   | Usual Residence of Decedent  |  | -   |                                   |                           |                 | June 1.                                 | 3, 1939   | west                                  | Virginia   | 1    |  |
|                     | how   |                   | 10a. State 10b. County   |  | ity, Town or L  | ocation                           |                           |                 |   |   | 1                                     | 0d. Inside City Lin                                |      |  |
|                     | Ba-f-e  | cto               | MD Dorche  | ster Cambridge   |   |                                   |                           |                 |   |   |                                       | 1 🙀 Yes 2 🗆  | No   |  |
|                     | vith th   | Director          | 10e. Street and Number   |  |   | 10f. Z                            | ip Code                   | 0               |   | 10g. Citizen o  |                                       |  |      |  |
|                     | e 23e   | Funeral           |  | mbridge Beltway 21613  |   |                                   |                           |                 | Specify Vec or N                        | Unite   | tes<br>an Indian,                     |  |      |  |
|                     | ter de  | Ę.                | 11. Marital Status  1 Never Married 2 Married  | 12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu |   |                                   |                           | Mexican, Puer   | to Rican, etc.)                         | В В   | lack, White,                          |  |      |  |
| Maryland 21215-0036 | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther then "natural", or fleme 23a or 28a-f ehow<br>that the Madical Examiner must be matified at   | ρ                 | 3 ☐ Widowed 4X☐ Divorced   | If Yes, Give<br>Year or Dates:   |   | 1 🗆 Yes                           | 2 <b>2</b> No 5           | Specify:        |   | Spec  | Specify: White                        |  |      |  |
| 2-0                 | 72 ho   | Completed         | 15. Decedent's Edu<br>(Specify only highest grad   |  | ecedent's Usual Occupation<br>live kind of work done during most of working<br>e. DO NOT use retired) |                                   |                           | irkina          | 16b. Kind of                            | b. Kind of Business/Industry                            |                                       |  |      |  |
| 2                   | on new  | ηbje              | Elementary/Secondary (0-12)  | College (1-4or 5+)   |   |                                   |                           |                 | ·······g                                |   |                                       |  |      |  |
| 2                   | tygier<br>ther th   | S                 | 12 17. Father's Name (First, Middle, Last)   |  | Home  | emak                              |                           | Mathada Na      | me (First, Middle                       | <u> </u>  | Own Home                              |  |      |  |
| anc                 | od of   | Be c              | Charles C. Huf   |  |   |                                   | 10                        |                 |   |   |                                       |  |      |  |
| 2                   | should Me<br>mark<br>matic  | ဥ                 | 19a. Informant's Name/Relationship (Ty   |  | 19b. Mail   | ina Addre                         | s (Street and             |                 | y M. Hi<br>ural Route Numb              |   | m. State. Zip                         | Code)  |      |  |
| 2                   | and 2:  |                   | Lisa A. Busick/  | Daughter   | (   |                                   |                           |                 | ., Dent                                 |   |                                       |  |      |  |
| re,                 | s 1 a<br>of Hei<br>item<br>othe   |                   | 20a. Method of Disposition   | 20b.   | Place of Disp<br>cemetery, cre  | osition (N                        | ame of other place)       |                 | Date                                    | 20c. Location   |                                       |  |      |  |
| Ē                   | Peges<br>nent of<br>ant: If it  |                   | 1  ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)   | ternoval irom State  | oncor   | d Ce                              | meter                     | y   07/         | 07/06                                   | Dent  | on, M                                 | aryland  | i    |  |
| Baltimore,          | permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or iteme 23a or 28a-1 show appriants: If item 27 is marked other than "natural; or iteme 23a or 28a-1 show apprintly or other traumatic event, the Mudical Examiner must be notified at ances. |                   | 21. Signature of Funeral Service Licens  | 90   | 2   | 2. Name                           | and Address o             | of Facility F 1 | amptom                                  | Fune  | ral H                                 | ome, P.  | Δ    |  |
| Ш                   | 80599   |                   | Muhar J.   | Iskow  |   | -10 1                             | • HGIH                    | ا و ما 🗆        | rederars                                | burg, r   | ID 216                                | 32   | 11 • |  |
|                     | icate be executed  Medical  Medical  Sthe burial-transit  |                   | 23a. Part1. Enter the disease, or complete shock, or heart failure. List only or   | ne cause on each line.   | ith. Do not en  | iter the m                        | ode of dying, s           | such as cardia  | c or respiratory a                      | arrest,   |                                       | Approximate<br>Interval Between<br>Onset and Death | ì    |  |
|                     |   |                   | Immediate Cause (Final disease or condition resulting in death)  a. HEART FAILURE  |  |   |                                   |                           |                 |   |   |                                       |  |      |  |
|                     |   |                   |  | Due to (or as a conte  | Due to (or as a consequence of):  Due to (or as a consequence of):                                    |                                   |                           |                 |   |   |                                       |  |      |  |
| ž. 44               |   | je l              | Sequentially list conditions, if any, leading to immediate cause. Enter of Jurying Cause (Disease or injury  | Due to (or as a conse  |   |                                   |                           |                 |   |   |                                       |  |      |  |
|                     |   | Examiner          | that initiated events  |  |   |                                   |                           |                 |   |   |                                       |  |      |  |
| 760,                | te be executed<br>ysicien and<br>ie burial-transit  |                   |  |  |   |                                   |                           |                 |   |   |                                       |  |      |  |
|                     |   | dicai             |  | d  |   |                                   |                           | _               |   |   | _                                     |  |      |  |
| × 68                | ding p  | Physician/Med     | IF FEMALE:   | 23c. If yes, outcome of pregr  | ancv  |                                   |                           |                 | 204.6                                   |   |                                       |  |      |  |
| Bo                  | atten<br>1 for u  | clan              | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No  | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)                               |   |                                   |                           |                 |   |   | 23d. Date of delivery  Month Day Year |  |      |  |
| P.O. Box            | t the c   | hysi              | 9 Unknown  | 9□ Unknown   |   |                                   |                           |                 |   |   |                                       |  |      |  |
|                     | Physician: The law requires that the death certifica this certificate has been signed by the attending phral director, page 2 should be detached for use as it  | by P              | Part II. Other significant conditions con  |  | 7   |                                   | -                         |                 | 23e. Did                                | tobacco use co  | ontribute to th                       | ne cause of death                                  | ?    |  |
| ğ                   | w require<br>been sig<br>should b   |                   |  |  |   |                                   |                           |                 |   |   | 3 🗌 Prob                              | ably 4 Onkn  | OWO  |  |
| Records,            | law ras be  | ple               | J  |  | 24a. Was  | stopsy prior to completion of cau |                           |                 | able<br>of                              |   |                                       |  |      |  |
|                     | : The law<br>cate has   | Completed         |  |  |   |                                   |                           |                 |   | ormed?<br>2 ☐ No  | ned? death?                           |  |      |  |
| Zii:                | ding Physiclan: Th<br>n.<br>After this certificate<br>funeral director, pag   | Be                | 25. Was case referred to medical examiner?   | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)                                      |   |                                   |                           |                 |   |   |                                       |  |      |  |
| ō                   | Phys<br>r this<br>ral dii   | . To              | 1 Yes 2 No   | 1 Inpatient 2L   | 18a. Date of Injury (Month, Day Year)  Real Properties 1  |                                   |                           |                 |   | how injury occ  |                                       | ()   |      |  |
| O                   | Attending r death. ector: After by the fune   | tlor              | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation   | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M  |   |                                   |                           | s 2 No          |   | o now injury occurred                                   |                                       |  |      |  |
| Division of Vital   | Atter   | Iffice            | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory office  |  |   |                                   |                           |                 |   | 28f. Location (Street and Number or Rural Route Number, |                                       |  |      |  |
|                     | tel or<br>rs afte<br>el Dir   | Certification:    | building, etc. (Specify)  City or Town, State)   |  |   |                                   |                           |                 |   |   |                                       |  |      |  |
|                     | t hour<br>uner<br>uner  |                   | 29a. Certifier Certifying Phy  | sician: To the best of my kn<br>ner: On the basis of examin  | owledge, dea  | th occurre                        | d at the time,            | date and plac   | e, and due to the                       | cause(s) and  | manner as st                          | ated.  |      |  |
|                     | To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer  | Medical           | (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date si |  |   |                                   |                           |                 |   |   | ned (Month, Day, Year)                |  |      |  |
|                     | Z × Z   |                   | 51   |  |   |                                   | 122                       |                 |   |   |                                       |  |      |  |
|                     |   |                   | 30. N e and ddress of erson who co   | mpleted cause of death (Ite  | m 23a) (Tvna  | . Print)                          | AU417                     | 1643581         | 67+1                                    | 11.100  | 12pm                                  | h  |      |  |
|                     |   |                   | 17   | yvazzadeh M  | 0   | 22                                | 5 G                       | reene S         | 6771<br>it. Bai                         | Itimure,  | MD                                    | 2120/  |      |  |
| 183                 | Sta   |                   | 31. Date filed (Month, Day, Year)  | 32. Régistrar's Sign   | ature   | 1                                 | ,                         |                 |   |   |                                       |  |      |  |
|                     | Regist  | ar                |  | Ub Compres   | 10 14   | 100                               | A                         |                 |   |   |                                       |  |      |  |

|            |  |                  | 1 - For<br>State<br>Registrar   | State  | of Mary   | land / Der<br>Ce                      | artment c<br>ertificate         |                                    |              | ental Hy                                   | ygien:<br>Reg. N | 2 U                     | 06                          | 22600  |  |
|------------|--|------------------|---|--|---|---------------------------------------|---------------------------------|------------------------------------|--------------|--|------------------|-------------------------|-----------------------------|--|--|
|            | Dhusia   | :                | Decedent's Name (First, M   | iddle, Last)   |   |                                       |                                 |                                    |              | 2. Date of D<br>Month                      | eath<br>Da       | av                      | Year                        | 3. Time of Death                             |  |
|            | Physic<br>/Medi  |                  | Mar   | y Louise I   | Hoerr   |                                       |                                 |                                    |              | June                                       |                  | Ž9,                     | 2006                        | 8:01 P                                       |  |
|            | Exami  |                  | 4a. Facility Name (If not institu   |  | number)   |                                       |                                 | wn, or Location                    |              |  | 40               | c. County               | of Death                    |  |  |
|            |  |                  | 239 Melr  | -  |   |                                       | Har                             | ford                               |              |  |                  |                         |                             |  |  |
|            | Funeral<br>Director  |                  | 5. Social Security Number 217–64–4277   | 6. Sex<br>1 □ M 2 √ F                                      |   | yrs. last birthda<br>48 Yrs.          |                                 | ear If Unde<br>ays Hours           | Min.         | 8. Date of B<br>(Month, D<br>March         | orth<br>O8,      | <sup>7</sup> 1958       | 9. Birthpl<br>Coup<br>Ma    | ace (State or Foreign<br>fry)<br>aryland     |  |
|            | and  |                  | Usual Residence of Deceden  10a. State 10b. Cou   |  | 10  | c. City, Town or                      | ocation                         |                                    |              |  |                  |                         | 10                          | Od. Inside City Limits                       |  |
|            | Mary   | ğ                | Maryland Ha   | rford  |   | Forest                                | Hill                            |                                    |              |  |                  |                         |                             | 1 □Yes 2t☑No                                 |  |
|            | r 28a  | Funeral Director | 10e. Street and Number  |  |   |                                       | 10f. Zip Co                     | de                                 |              |  | 10g. C           | itizen of V             | What Count                  | try?   |  |
|            | th wit   | a D              | 239 Melrose C   | ourt   |   |                                       | 210                             | 050                                |              |  | USA              | SA                      |                             |  |  |
|            | dea  | ner              | 11. Marital Status  | 12. Was D  | ecedent Ever<br>Forces?                         | r in U.S. 13                          | Was Decedent<br>If Yes, specify |                                    | rigin? (Spec | ofy Yes or N                               |                  | 14. Race                | e - America                 | an Indian,                                   |  |
| 215-0036   | s. 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentai Hygiene. "natural", or items 23a or 28a-f show other treumatic event, the Madical Examinar must be notified at | þ                | 1 ☐ Never Married 2 ☐ I 3 ☐ Widowed 4 🛣 Divor   | Marned 1 TY e  | Sive X<br>Give X<br>r Dates:                    |                                       | 1 ☐ Yes 2X                      |                                    |              | ilican, etc.)                              |                  |                         | ck, White, e<br>/* Whit     |  |  |
| 5-0        | 72 ho  | Completed        | 15. Dece<br>(Specify only hi  | dent's Education<br>ghest grade complete                   | ad)   |                                       | edent's Usual O                 |                                    | st of workin | ıa.  | 16b. F           | Kind of Bu              | usiness/Ind                 | ustry  |  |
| 121        | within ene.  | ğ                | Elementary/Secondary (0-1   |  | e (1-4or 5+)                                    | life.                                 | DO NOT use re                   | etired)                            |              | 9  |                  |                         |                             |  |  |
| 121        | filed v<br>Hygie<br>ther t   |                  | 12<br>17. Father's Name (First, Mide  | de (ast)   |   | C1                                    | erk_                            | 19 Moth                            | or's Name    | (First, Middle                             |                  | etail                   |                             |  |  |
| Maryland   | d be<br>ontal  | Be               | Charles E. Br   |  |   |                                       |                                 |                                    |              | a Lane                                     |                  |                         | ,                           |  |  |
| 2          | 2 should tand Ment<br>Is marked  | ၉                | 19a. Informant's Name/Relati  |  |   | 19b. Mai                              | ling Address (St.               |                                    |              |  |                  |                         |                             | Code)  |  |
| M          | nd 2 ulth ar lith ar 27 is   |                  | Vicki Brooks  |  | n-law   |                                       | O Adv Ro                        |                                    |              | lle, N                                     |                  |                         | 2113                        |  |  |
| J.         | of Health<br>of Health<br>Iltem 27 I   |                  | 20a. Method of Disposition  |  | 2   | Ob. Place of Disp                     | osition (Name of                | of I                               |              | ate  |                  |                         | City or Tov                 |  |  |
| Baltimore, |  |                  | 1 □ Burial 2 ☑ Cremati<br>4 □ Donation 5 □ Othe   |  |   | Evans Ea                              |                                 |                                    | July         | 6, 200                                     | 16               | Le                      | eola,                       | Pa. 17540                                    |  |
| Salt       | permit. Pag<br>Department<br>Important: I<br>any Injury c  |                  | 21. Signature of Funeral Serv   | ice Licensee   | 0 1   |                                       | 22. Name and A                  |                                    |              |  | 60               | 00 Ma                   | in St                       | treet  |  |
|            | 20 E # 9   |                  | Harkins Funeral Home, Inc. Delta, Pa. 17314   |  |   |                                       |                                 |                                    |              |  |                  |                         |                             |  |  |
|            |  |                  | 23a, arr . End it disease in commence on sthat caused the dear bid Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between,  |  |   |                                       |                                 |                                    |              |  |                  |                         |                             |  |  |
| 1          | Physician<br>/Medical<br>Examiner  |                  | Immediate Cause (Final disease or condition resulting in death)   | a  | Metol   | tanic                                 | lun                             | & Ca                               | MCO          |  |                  |                         | 1                           | Onset and Death                              |  |
|            |  |                  | rooding in death)   | Due  | to (or as a co                                  | nsequence of):                        |                                 | 0                                  |              |  |                  |                         |                             | <i>y</i> •••                                 |  |
|            |  | ě                | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):   |  |   |                                       |                                 |                                    |              |  |                  |                         |                             |  |  |
|            | uted   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.  |  |   |                                       |                                 |                                    |              |  |                  |                         |                             |  |  |
| oʻ         | exec<br>en an  | Exa              | resulting in death) Last  Due to (or as a consequence of):  |  |   |                                       |                                 |                                    |              |  |                  |                         |                             |  |  |
| 8760,      | icate be executed<br>physicien and<br>s the burial-transit   | dlcal            |   | d  |   |                                       |                                 |                                    |              |  |                  |                         |                             |  |  |
| θ          | artifica<br>ing pt   | Med              | IF FEMALE:  |  |   |                                       |                                 |                                    |              |  |                  |                         |                             |  |  |
| Вох        | death certific<br>ettending p<br>d for use es  | an/              | 23b. Was decedent pregnant in the past 12 months?   | 1⊡Liv  | outcome of pre-<br>birth 2 🗌                    | Fetal death 3                         | □Ectopic pregna                 | ancy                               |              |  |                  |                         | e of deliver                | •  |  |
|            | the e  | yslc             | 1 ☐ Yes 2 ☐ No  | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 ☐ Other (specify) |   |                                       |                                 |                                    |              |  |                  | Month Day Year          |                             |  |  |
| P.0        | The law requires that the death certif<br>ate has been signed by the ettending<br>page 2 should be detached for use es   | by Physician/Me  | Part II. Other significant cond   | titions contributing to                                    | death but no                                    | ot resulting in the                   | underlying cause                | a criven in Part                   |              | 23e. Did tobacco use contribute to the cau |                  |                         | cause of death?             |  |  |
| Records,   | uires that<br>signed h   |                  | _   | · ·  |   | •                                     |                                 | g                                  |              |  |                  |                         | 3 ☐ Proba                   |  |  |
| S          | w requir<br>been s   | ete              |   |  |   |                                       |                                 |                                    |              | 24a. Was                                   |                  | 24h M                   | Vara auton                  |  |  |
| Re         | The lav  | Completed        |   |  |   |                                       |                                 |                                    |              | auto                                       |                  | đ                       | eath?                       | sy findings available<br>pletion of cause of |  |
| Vital      | ician: Th<br>certificate<br>rector, pag  | BeC              | 25. Was case referred to med  | lical  |   |                                       |                                 | 26 Place                           | e of Death   | 1 ☐ Yes<br>Check only                      | 2 X No           | 1                       | ☐ Yes 2                     | 2 ( <b>3K</b> No                             |  |
| >          | Q 20   | To B             | examiner?<br>1 ☐ Yes 2 ☑No  | Hospital:  | ☐ Inpatient                                     | 2 ER/Outpatie                         | nt 3 DOA                        | Other                              |              | e 5 Resi                                   |                  | 6 □Othe                 | ar (Snecify)                |  |  |
| J Of       | ding Ph<br>h.<br>After th<br>funeral   |                  | 27. Manner of Death   | 28a. Da  | te of Injury<br>onth, Day Yea                   |                                       |                                 | Injury at<br>Work?                 |              | 3d. Describe                               |                  |                         |                             |  |  |
| Sio        | Attending in death.  | atlc             | E   | estigation   |   | in flat y                             |                                 | 1 Yes 2                            | No           |  |                  |                         |                             |  |  |
| Division   | 2 2 2 2  | Certification;   | 3 Suicide 4 Homicide  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Num City or Town, State) |  |   |                                       |                                 |                                    |              |  |                  | Route Number,           |                             |  |  |
|            | To the Hospital or Attentwithin 24 hours effer death To the Funeral Director: completely filled in by the  | Medical (        | 29a. Certifier 1 Certi<br>(Check only one) 2 Medi   | fying Physicien: To<br>cal Examiner: On the<br>and m       | the best of my<br>basis of exa<br>anner stated. | y knowledge, dea<br>mination and/or i | th occurred at th               | e time, date ar<br>ny opinion, dea | nd place, an | nd due to the<br>d at the time,            | cause(s)         | ) and mar<br>d place, a | nner as sta<br>and due to t | ted,<br>the cause(s)                         |  |
|            | To th<br>withir<br>To th<br>comp   | Me               | 29b. Signature and title of cer   | fier   | 4.4   | ^                                     | 29c. Lic                        | ense number                        |              |  | 29d. Da          | te signed               | (Month, 6                   | ay, Year)                                    |  |
|            |  |                  | West  |  | MC  | 1)                                    | 1                               | 184                                | 87           |  |                  | 6/-                     | 30/2                        | 100 G  |  |
|            |  |                  | 30. Name and address of pers  | on who completed ca  | use of death                                    | (Item 23a) (Type                      | , Print)                        |                                    | · · ·        | l_   |                  |                         |                             |  |  |
| 900        |  |                  | 602 5.1   | 1TWOOD   | 60  | AD, S                                 | TE 2                            | 00, 1                              | BEL          | AIR  | . 2              | 101                     | 14                          |  |  |
|            | Sta<br>Registi   |                  | 31. Date filed (Month, Day, Ye  | ar) 32   | . Registrar's S                                 | -                                     | 1-1                             |                                    |              |  |                  |                         | 1                           |  |  |
| DH         | MH 17 Rev 1/2  |                  | JUL 1   | 7 2006   | The state of                                    | Nº A                                  | more                            |                                    |              |  |                  |                         |                             |  |  |
|            | 1164 1/2   | 501              |   | -5   |   |                                       |                                 |                                    |              |  |                  |                         |                             |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 10e 21 per fh 8857 7-15-06 vt.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 07 09 2006 9:50 Darlene Joy Hurley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 902 Crystal Road Edgewater 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/19/1933 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 KF Yrs. 578-40-5030 72 Kentucky Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or iteme 23e or 28a-f show the Medical Examiner must be notified at 1 Yes X No Anne Arundel Edgewater Completed by Funeral Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21037 U.S.A. 902 Crystal Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🐼 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 ☐Widowed 4 € Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland 10 Data Entry Operator other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill iment of Health and Mental Hitant: If item 27 is marked off Pauline Wolfenberger Thomas Altman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health an Important: if Item 27 ie eny injury or other treu QDCB. Patricia Darlene Dixon/daughter 902 Crystal Road, Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Memorial Gardens 7/12/06 Davidsonville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee 2973 Solomons Island Rd., Edgewater, MD 21037 Bob Kalas per dvr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Congostive Immediate Cause (Final **Physician** 48409 disease or condition resulting in death) /Medical Examiner Ischance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Matural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: , completely tilled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharan Messies/MP. 2629 Riva Rd. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Pages 1 and 2 should be filed within 72 hours after death with the Maryland r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

**Funeral** Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

|   | 577-08-16   | 591               | 'X' M             | 201  | 25           | Yrs.  |  |            | <u> </u>  |            | 02/2                                    | 21/19  | 81                                 | Was         | hingto       | on, DC |  |
|---|---|-------------------|-------------------|--|--------------|---|--|------------|---|------------|---|--|------------------------------------|-------------|--------------|--------|--|
| -                                       | Usual Residence of  |                   |                   |  | . Town or Lo | antion  |  |            |   |            |   |  |                                    | 10d Inside  | City Limits  |        |  |
| 5                                       | D.C.  | 10b. County       |                   | 10c. City, Town or Location  Washington  |              |   |  |            |   |            |   |  |                                    | Y□Yes 2□No  |              |        |  |
| ect                                     | 10e. Street and Nur   | mbac              |                   |  |              | vvasiiiii   | _  | ip Code    |   |            | -                                       | 100.0  | itizen of                          | What Co     | untry?       |        |  |
| 급                                       | 854 52nd  |                   | - N.              |  | 7            |   | 101. 2   | 200        | 19  |            |   |  | 10g. Citizen of What Country?  USA |             |              |        |  |
| To Be Completed by Funeral Director     | 11. Marital Status 1 ☑ Never Marri 3 ☐ Widowed  | ied 2□ Mar        | ned 12.           | Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give                    |              |   | 3. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc)  1 Yes 2X No Specify: |            |   |            |   | es or No-<br>etc.) 14. Race - American India<br>Black, White, etc.<br>Specify: Black |                                    |             | e, etc.      |        |  |
| ted b                                   |   | 15. Deceder       | nt's Educat       | Year or Da   | ates:        | 16a. Decedent's Usual Occupation (Give kind of work done during most of w |  |            |   |            | 16b. Kind of Business/Industr           |  |                                    |             |              |        |  |
| mple                                    | Elementary/Seco   |                   | ist grade t       | College (1-4or 5+)   |              |   | ifie. DO NOT use retired)  |            |   |            |   |  | Private                            |             |              |        |  |
| ပိ                                      | 17. Father's Name   | (First Middle     | Last)             |  |              | 18. Mother's Name (First, Middle, Maiden Sumarm                           |  |            |   |            |   |  |                                    |             | a)           |        |  |
| o Be                                    | Samuel  |                   |                   | Sr.  |              |   |  |            | Ch  | erry       | Fogl                                    | е  |                                    |             |              |        |  |
| ř                                       | 19a. Informant's N  |                   |                   |  |              | 19b. Mailir   | ng Addre   | ss (Street | and Numb  | per or Rui | ral Route Ni                            | ımber, City  | or Town                            | n, State, 2 | Zip Code)    |        |  |
|   | Samuel L  |                   |                   |  |              | 854   | 52nd   | Str        | eet,  | N.E.       | WDC                                     | 200  | 19                                 |             |              |        |  |
|   | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location   |                   |                   |  |              |   |  |            |   |            | tion - City or Town, State              |  |                                    |             |              |        |  |
|   | 4 Donation 5 Other (Specify) Riverdale Crematory 07/03/2006 Riverdale,  |                   |                   |  |              |   |  |            |   |            |   |  |                                    | Land        |              |        |  |
|   | 21. Signature of Truneral Service Licensee 22. Name and Address of Facility FREEMAN FUNERAL SERVI 5801 Cleveland Avenue; Riverdale, MD  |                   |                   |  |              |   |  |            |   |            |   |  |                                    |             | 37           |        |  |
|   | 23a. Part1. Ener the disease or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):                     |                   |  |              |   |  |            |   |            |   | Approxin<br>Interval I<br>Onset ar   |                                    |             |              |        |  |
| Completed by Physician/Medical Examiner |   |                   |                   |  |              |   |  |            |   |            |   | RONK   |                                    |             |              |        |  |
| ysician/Me                              | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  |                   |                   |  |              |   |  |            |   |            | 23d. Date of delivery<br>Month Day Year |  |                                    |             |              |        |  |
| d by Ph                                 | ACUTE RENAL HILLIAE   |                   |                   |  |              |   |  |            |   |            |   | co use contribute to the cause of death?  2  |                                    |             |              |        |  |
| ompiete                                 | autopsy prior performed? death  |                   |                   |  |              |   |  |            |   |            |   | prior to death?  |                                    |             |              |        |  |
| d)                                      | 25. Was case refe   | rred to medic     | al                |  |              |   |  |            | 26. Plac  | ce of Dea  | th (Check o                             |  |                                    |             |              |        |  |
| To B                                    | examiner?   | No                | Ho                | spital: 1 D  | Inpatient 2  | ER/Outpatie   | nt 3 🗆   | DOA Ot     | her: 4   N  | lursing H  | ome 5 🗆                                 | Residence  | 6 □0                               | ther (Spe   | icity)       |        |  |
| tion:                                   | 27. Manner of Dea<br>1 PNatural<br>2 Accident   | 5 🗌 Pend          | ling<br>tigation  | 28a. Date of Injury (Month, Day Year)  28b. Time of Injury                             |              |   |  |            |   |            | 28d. Desc                               | Describe how injury occurred   |                                    |             |              |        |  |
| Medical Certification;                  | 3 ☐ Suicide<br>4 ☐ Homicide   | 6 Could deter     | d not be<br>mined | 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) |              |   |  |            | 28l. Location (Street and Number or Rural Route Number,<br>City or Town, State) |            |   |  |                                    |             |              |        |  |
| dical C                                 | 29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |                   |                   |  |              |   |  |            |   |            |   | 60(S)  |                                    |             |              |        |  |
| Me                                      | 29b. Signature and  | d title of certif | ier               |  | ATTEN        | NING  | - 1  | 29c. Licen | se number   | r          |   | 29d. I   | -                                  |             | th, Day, Yea |        |  |
|   |   |                   | _                 |  | 01           | 1. 1  |  |            | 5791  | 20         |   |  | 01-                                | 7           | 1            | 2006   |  |

State

ddress of person who completed cause of death (Item 23a) (Type, Print)

8700 Centra

MOMOH

31. Date liled (Month, Day, Year)

JUL 0 3 2006

|                   |  |                  | For State Registrar   | State of Mary  |                                     |                         | of Health and                   | d Mental Hy                  | giene                                 | 22509  |
|-------------------|--|------------------|---|--|-------------------------------------|-------------------------|---------------------------------|------------------------------|---------------------------------------|--|
|                   |  |                  | Decedent's Name (First, Middle, Las   | t)   |                                     |                         |                                 | 2. Date of De                |                                       | 3. Time of Death                                     |
|                   | Physicia   |                  | Leslie Berwyn Jon   |  |                                     |                         |                                 | June 2                       | 9, 2006                               | 5:40am <sup>M</sup>                                  |
|                   | /Medic<br>Examin   |                  | 4a. Fecility Name (If not institution, give   |  |                                     | 4b. City, Tox           | wn, or Location of D            |                              | 4c. County of De                      |  |
|                   | LAGITITI   | ۲.               | Fairland Nursing  | & Rehab Cent   | ter                                 | Silver                  | Spring                          |                              | Montgome                              | erv  |
|                   | Funeral  |                  | Social Security Number     6. Security Number   | 7. Age (In   | yrs. last birthday)                 | II Under 1 Y            | ear If Under 24 I               | Hrs. 8. Date of Bi           | rth 9. B                              | irthplaca (State or Foreign<br>Country)              |
|                   | Director   |                  | 114-22-1459   | ©M 2□F 9   | 2 Yrs.                              | Months                  | ays Hours K                     | Sep 15                       | , 1913 Ne                             | w York   |
|                   | D .  |                  | Usual Residence of Decedent   | 100  | . City, Town or Le                  | nontin n                |                                 |                              |                                       | 10d. Inside City Limits                              |
|                   | anyla<br>ehov  | <u>-</u>         | 10a. State 10b. County  |  | -                                   |                         |                                 |                              |                                       | 1 ☐ Yes 2 🖾 No                                       |
|                   | 8a-f   | Directo          | Maryland   Montgome   | ry (   | Gaithers                            |                         |                                 |                              | 10.00                                 |  |
|                   | or 2   | Ö                | 10e. Street and Number  |  |                                     | 10f. Zip Co             |                                 |                              | 10g. Citizen of What (                | •  |
|                   | e 23   | Funerai          | 20900 Goshen Road   | 12. Was Decedent Ever                                    | in II C 12                          | 208                     |                                 | ? (Specify Yes or No         | United St                             | ates   |
|                   | lten de  | .nu              | 11. Marital Status  1 □ Never Married 2 □ Married   | Armed Forces? 1 ★ Yes 2 No                               | 110.3.                              | If Yes, specify         | Cuban, Mexican, P               | uerto Rican, etc.)           | Black, Wh                             |  |
| 5                 | hours after death with the Maryland<br>Lural', or Iteme 23a or 28a-1 show<br>at Examinar must be modified at   | by F             | 3X Widowed 4 □ Divorced   | If Ves Give  | WII                                 | 1 ☐ Yes 2 🔀             | No Specify:                     |                              | Specify:                              | Thite  |
| 9500-61212        | 2 hou  | ted              | 15. Decedent's Ed   | ucation  | 16a. Dece                           | dent's Usual C          | Occupation                      |                              | 16b. Kind of Busines                  |  |
| ב<br>ב            | within 72<br>ene.<br>then nai  | pie              | (Specify only highest gra<br>Elementary/Secondary (0·12)  | College (1-4 or 5+)                                      | life.                               | DO NOT use i            | done during most of<br>retired) | working                      |                                       |  |
| 7                 | a filed within al Hygiene. I other then vent, the Ma   | Completed        |   | 2  | Regi                                | stered                  | Nurse                           |                              | Hospital                              | S  |
| Maryland          | be filed within 72 hours after death with the Marylan tal Hygiene. d other then "natural", or lieme 23a or 28a-1 show event, it is Madical Examinar must be collified at | Be (             | 17. Father's Name (First, Middle, Last)   |  |                                     |                         | 18. Mother's                    | Name (First, Middle          | , Maiden Sumame)                      |  |
| <u>a</u>          |  | 일                | David Jones   |  |                                     |                         | Gertru                          | ıde Griff:                   | ith                                   |  |
| a<br>L            | 2 should<br>and Men<br>ie marke<br>raumatic  |                  | 19a. Informant's Name/Relationship (7   | ype, Print)  | 19b. Maili                          | ng Address (S           | treet and Number o              | r Rural Route Numb           | er, City or Town, State               | Zip Code)  |
|                   | s 1 and 2 should<br>f Health and Mer<br>Item 27 ie marke<br>other traumatic  |                  | Elaine A. Powell  | (Daughter)   |                                     |                         |                                 |                              | urg, MD 208                           |  |
| 9                 | or oth   |                  | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐   | removal from State                                       | Ob. Place of Dispo<br>cemetery, cre |                         | 1                               | Date                         | 20c. Location - City of               | or Town, State                                       |
|                   | permit. Pages Depertment of the Important: If Ite eny Injury or of once.   |                  | 4 □ Donation 5 □ Other (Specify   |  | 1etropol                            | itan Cr                 | ematory 6                       | 5/30/06                      | Alexandria                            | , Virginia   |
| Baltimore,        | Depermine Mpoor  |                  | 21. Signature of Funeral Service Lisen  | see A  | 1                                   | 2. Name and A<br>O East | Deer Park<br>burg, MD           | Devoi rui<br>CDr <u>i</u> ve | neral Home                            |  |
|                   | 40104  |                  | 23a. Part 1. Enter the disease, or comp   | plications that caused the                               |                                     |                         |                                 |                              | arract                                | Approximate  |
|                   |  |                  | shock, or heart failure. List only  | one cause on each line.                                  | death. Do not en                    | ter the mode o          | dyllig, such as car             | diac or respiratory a        | 11031,                                | Interval Between<br>Onset and Death                  |
| ,                 | Physician /Medical   |                  | disease or condition resulting in death)  | a Progressiv   |                                     | imers D                 | isease                          |                              |                                       |  |
|                   | Examiner   |                  |   | Due to (or as a co                                       | nsequence or):                      |                         |                                 |                              |                                       |  |
|                   | <b>3.</b>  | er               | Sequentially list conditions, if any, leading to immediate  | b. Due to (or as a cor                                   | nsequence of):                      |                         |                                 |                              |                                       |  |
|                   | uted<br>d<br>ansit   | Examiner         | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | C  |                                     |                         |                                 |                              |                                       |  |
| o Î               | be executed<br>icien and<br>burial-transit   |                  | resulting in death) Last  | Due to (or as a con                                      | nsequence of):                      |                         |                                 |                              |                                       |  |
| 3760,             | et e   | icai             | (   | d  |                                     |                         |                                 |                              |                                       |  |
| 9                 | death certifical<br>e attending phy<br>d for use as th   | Med              | IF FEMALE:  |  |                                     |                         |                                 |                              |                                       |  |
| . Box             | ath ce<br>ttendi   | lan/l            | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of pr                               | Fetal death 3                       | ⊒Ectopic pregr          |                                 |                              | 23d. Date of d<br>Month               | elivery<br>Day Year                                  |
| o<br>O            | 0 0 0  | by Physician/Med | 1 Yes 2 No  | 4☐Pregnant at time<br>9☐ Unknown                         | of death 5                          | Other (speci            | fy)                             |                              | Wighti                                | ou, ou.  |
| 1                 | thet if  | Ph               | Part II. Other significant conditions of  | ontributing to death but no                              | t resulting in the I                | inderlying caus         | se given in Part I              | 23e. Did                     | tobacco use contribute                | to the cause of death?                               |
| Records,          | 8 5 0  | d by             | Hypotension   | <b>3</b>   | <b>3</b>                            | ,                       | <b>9</b>                        |                              |                                       | Probably 4 XUnknown                                  |
| Ö                 | w require<br>been sign   | ete              |   |  |                                     |                         |                                 | 24a. Was                     | 245 14/242                            |  |
| ě                 | hysician: The law<br>nis certificate has t<br>I director, page 2 s   | Completed        | Urinary Tract Inf   | ection   |                                     |                         |                                 | _ auto                       | psy prior to death?                   | autopsy findings available<br>completion of cause of |
| ē                 | n: Ti<br>ficate<br>or. pa  |                  | 25. Was case relerred to medical  |  |                                     |                         | 00 Bloom                        | 1 ☐ Yes                      |                                       | es 2 No  |
| 5                 | Physician:<br>this certific<br>ral director.   | To Be            | examiner?<br>1 ☐ Yes 2 ☒ No   | Hospital:  | 2 ER/Outpatie                       | ot 3 🗆 DOA              | Other                           | Death (Check only            | one)<br>idence 6 □Other (Sp           | agait ()   |
| ō                 | <u> = e</u>  |                  | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Yes                   |                                     |                         | Injury at Work?                 |                              | how injury occurred                   | ocny)  |
| <u></u>           | Attending in death.  | atlo             | 1   Natural 5  Pending 2  Accident investigation  |  | ar) Injury                          | м                       | Work?<br>1 ☐ Yes 2 ☐ No         |                              |                                       |  |
| Division of Vital | or Attendate death Director:   | liffica          | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined   | 28e. Place of Injury -<br>building, etc. (S              | At home, farm, st                   | reet, factory, o        | ffice                           |                              | (Street and Number or I<br>wn, State) | Rural Route Number,                                  |
| 5                 | ours after<br>seral Directiled in by   | Certification:   |   | banang, oto. (5)   |                                     |                         |                                 | 0.1, 0.10                    | m, olalo)                             |  |
|                   | Hospital or 24 hours afte     Funeral Dir     Intely filled in I   | edicai           | (Check only 2 Medical Exan  | ysician: To the best of my<br>niner: On the basis of exa | knowledge, deal                     | th occurred at to       | the time, date and p            | lace, and due to the         | cause(s) and manner a                 | as stated.<br>ue to the cause(s)                     |
|                   | To the Hoe within 24 hr To the Fun completely  | Med              | 29b. Signature and title of certifier   | and manner stated.                                       |                                     | 29c. L                  | icense number                   |                              | 29d. Date signed (Mo                  | oth Day Year)  |
| -                 |  |                  | · MA  | 10   | // .                                |                         |                                 |                              |                                       |  |
| f                 | 5+1  |                  | 30. Name and address of person who  | completed cause of death                                 | (Item 23a) (Type                    |                         | 52261                           |                              | June 29, 2                            | 000  |
|                   |  |                  | Alan R. Segal, MI   |  |                                     |                         | Spring.                         | MD 20906                     |                                       |  |
| v                 | Sta  | te               | 31. Date filed (Month, Day, Year)   | 32. Rigistrar's S  | Signature                           | Carles                  | 10,                             |                              |                                       |  |
|                   | Registr  |                  | JUL 03  | 2006   | . 15 M                              |                         |                                 |                              |                                       |  |

|   | 1             | State of Maryland / Department of Health  State of Maryland / Department of Health  Certificate of Deat   |                                 |                                       | iene 2006  | 22610   |
|---|---------------|---|---------------------------------|---------------------------------------|--|---|
| WI WE   |               | 1. Decedent's Name (First, Middle, Last)  |                                 | 2. Date of Deat                       | h  | 3. Time of Death                              |
| Physician<br>/Medical   | _             | GWENDOLYN ANN JACKSON   |                                 | July 9,                               | 2006   | 3:02pm M                                      |
| Examine   | -66           | 4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Locatio  | on of Death                     |                                       | 4c. County of Death                                |   |
| ,   |               | Civista Medical Center LaPlata  Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Und  | der 24 Hrs.                     | 8. Date of Birth                      | Charles  | place (State or Foreign                       |
| Funeral Director  |               | 5. Social Security Number 6. Sex $1 \square M 2 \square F$ 7. Age (In yrs. last birthday) If Under 1 Year 1 | rs Min.                         | (Month, Day,                          | Year) Coul.  | place (State or Foreign<br>ntry)              |
|   |               | Usual Residence of Decedent   |                                 | IAYL_S_                               |  |   |
| show  |               | 10a. State 10b. County 10c. City, Town or Location  MARYLAND CHARLES WHITE PLAINS   |                                 |                                       |  | 10d. Inside City Limits<br>1 ☐ Yes 2XXVo      |
| vith the Mai  |               |   |                                 | 1                                     | 0g. Citizen of What Cou                            |   |
| with t  |               | 10e. Street and Number         10f. Zip Code           10443 SEXTANT PLACE         20695  | <u>.</u>                        | 1                                     | U.S.A.   | nuy:  |
| ritter death viriter death viritema 23c   | 2             | 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic (  |                                 | ofy Yes or No-                        | 14. Race - Ameri                                   |   |
| or Iter   | ב             | Armed Forces?  1 ☐ Never Married 2X Married  If Yes, specify Cuban, Mexic  If Yes, Sive  1 ☐ Yes 2 No Specify Cuban, Mexic  If Yes, Give  1 ☐ Yes 2 No Specify Cuban, Mexic   |                                 | ilcan, etc.)                          | Specify: D.T.                                      |   |
| tiled within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28e-f show ant, the Medical Exacity annual be notified at   | y D           | 3 Widowed 4 Divorced Year or Dates:   |                                 |                                       | BLA  |   |
| nati  | Completed     | 15. Decedent's Education (Specify only highest grade completed)  (Give kind of work done during m   | nost of working                 | g                                     | 16b. Kind of Business/Ir                           | •   |
| within iene.  | 5             | Elementary/Secondary (0-12) College (1-4or 5+) 1 2 3 HUMAN RESOURCE   | MANAC                           |                                       | J.S. GOVEI<br>NAVAL RESI                           |   |
| be tiled<br>tal Hygi<br>d other<br>event,   |               |   |                                 |                                       | Maiden Surname)                                    |   |
| 2 should be tiled within and Menial Hygiene. Is marked other than sumatic evant, the M  | 0             | LEONARD STANCIL VER   | RONICA                          | MILLS                                 | S  |   |
| and le ma   |               | 19a. Informant's Name/Relationship (Type, Print)  GREGORY R. JACKSON-HUSBAND 10443 SEXTANT  |                                 |                                       |  |   |
| s 1 and 2 should be tiled within 72 hours atter death with the Maryla Health and Mental Hygiene. To Bo Committee the Linears Director | -             | GREGORY R. JACKSON-HUSBAND 10443 SEXTANT  20a. Method of Disposition (Name of   |                                 |                                       | 20c. Location - City or T                          |   |
| permit. Pages 1 an<br>Department of Heali<br>Important: If item 2<br>any Injury or other<br>once.   |               | 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)   | 7-18                            | •                                     | VALHALLA,  |   |
| nit. Parame<br>artme<br>ortani<br>Injury  | 1             | 21 Signature of Veral Service Licenses MO 1470 22 Name and Address of Fac   | acility                         |                                       |  | NEW TORK                                      |
| permit. Departimont Import any inj  |               | RAYMOND FU  |                                 | 0.00 Hz 7 1 100 1                     | ICE, P.A.  |   |
|   |               | 23a. Part1. Enter the disease, or complication, that caused the death. Do in the inter the mode of dying, such shock, or heart failure. List only on that se on each line.  | yas cardiac or                  | respiratory arr                       |  | Approximate<br>Interval Between               |
| Physician   |               | Immediate Cause (Final disease or condition Respiratory   | ally                            | je .                                  |  | Onset and Death                               |
| /Medical<br>Examiner  |               | resulting in death)  Due to (or as a consequence of):   | 20                              | mid_                                  |  |   |
|   | ١             | Sequentially list conditions, if any leading to immediate  Due to (or as a consequence of):   | 14.                             |                                       |  |   |
| O-B ig  | ulue<br>u     | cause. Enter Underlying Cause (Disease or injury  Cause (Disease or injury  | Kerle-                          | · Juny                                | -  |   |
| oxecon and ial-tra  | Examiner      | that initiated events resulting in death) Last Due to (or as a consequence of):   |                                 |                                       |  |   |
| princis pe  | ca<br>Ca      | d   |                                 |                                       |  |   |
| The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the   |               | IF FEMALE:  |                                 |                                       |  |   |
| ath cer<br>ittendir   | any           | 23b. Was decedent pregnant in the past 13 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy   |                                 |                                       | 23d. Date of deliv<br>Month                        | ery<br>Day Year                               |
| the d   | Pnysician/med | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify)  |                                 |                                       |  |   |
| wrequires that the death certifical been signed by the attending phathough be detached for use as t   |               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa   | art I.                          | 23e. Did to                           | bacco use contribute to                            | the cause of death?                           |
| law requires that some signs as been signs 2 should be  | ed by         | Seizure seconday To M   | 012                             | 187                                   | s 2 No 3 Pro                                       | bably 4 Unknown                               |
| aw re   | plet          |   |                                 | 24a. Was a                            | n 24b. Were auto                                   | opsy findings available ompletion of cause of |
| The I   | Completed     |   |                                 | perfori                               | med? death?  |   |
| VII.di<br>ician: T  | Bec           | examiner?   | lace of Death                   | (Check only on                        | 10)  |   |
| Physi<br>r this c   | 0             |   |                                 |                                       | ence 6 Other (Speci                                | fy)   |
| ding ding h.  | tlon:         | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28b. Time of Injury Work?  1 Yes 2  |                                 |                                       | ow injury occurred                                 |   |
| Attending or death.  Tector: Alte by the func   | ertificat     | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office   | 2                               | 8f. Location (Si<br>City or Town      | treet and Number or Rur                            | al Route Number,                              |
| S afte or all Direction I   | Cert          | 4 ☐ Homicide determined building, etc. (Specify)  |                                 | Oily Of TOW                           | , State)   |   |
|   | edical        | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, of and manner stated.   | e and place, a<br>death occurre | ind due to the c<br>ed at the time, d | ause(s) and manner as a<br>late and place, and due | stated.<br>to the cause(s)                    |
| Nithin<br>Fo the<br>comple  | Me            | 29b. Signature and title of certified 29c. License number   | per                             | 2                                     | 9d. Date signed (Month,                            | 17  |
|   |               | 57708   |                                 |                                       | 7-10-1   | 06  |
| 8   |               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Addas A. Omais, MD, Cenna Medical Center, 7C Post   | Office                          | Rd., W                                | aldorf,MD 2  | 0602  |
| Stat<br>Registra  |               | 31. Date filed (Month) Perv. Year) 8 2006 32. Aegistrar's Signature   |                                 | 1                                     |  |   |

Guerdiya A. Jackson

#### 06 An

| 6-04502   |                                  |   | Ple  | ase Type   | or Print                 | in B                     | lack li                       | ndeli         | ble In              | k           |                   |  |                              |                     |   |                |
|---|----------------------------------|---|--|--|--------------------------|--------------------------|-------------------------------|---------------|---------------------|-------------|-------------------|--|------------------------------|---------------------|---|----------------|
| ngel Crisolo-Jui  |                                  |   | ate of Mai   | ryland / De  |                          |                          |                               | and           | Menta               | аі нус      | giene             |  | 0.0                          | 20                  | - 00  | - 1            |
|   | P                                | - For State<br>legistrar  |  |  | Certificat               | e or t                   | Jealii                        |               |                     | 12          | Date of De        | Reg. No                                |                              | <u> Hilli</u>       | 3. Time of Death                              |                |
| Physicia<br>Iedical Examir  | ner                              | i. Decedent's Name (First, Middl<br>Angel Jonatha   | an Criso   |  | a                        |                          |                               |               |                     |             | Month<br>June 27, | Day<br>2006                            | Year                         |                     | 1152 hrs                                      |                |
|   |                                  | 4a. Facility Name (if not institution University Hospital   | n, give street ar                                      | nd number)   |                          | 4b                       | Baltimo                       |               | cation of           |             |                   |  | c. County of                 |                     |   |                |
| Funeral   |                                  | 5. Social Security Number   | 6. Sex   | 7. Age (In y   | rs. last birthd          | ay)                      | If Under                      | $\overline{}$ | If Under            | _           | 8. Date of E      | Birth(MN                               | //DD/YYYY)                   | 9. Birth<br>Foreign | nplace (State or                              |                |
| Director  |                                  | 215-53-5435   | 1 X M 2  | F  | 20                       | Yrs.                     | Months                        | Days          | Hours               | Min.        | May 8             | . 19                                   | 86                           |                     | intry) Peru                                   |                |
| Baltimore, MD 21215-0036  Baltimore, MD 21215-0036  bermit. Pages I and 2 should be filed within 72 hours after death with the Maryland  pepartment of Health and Mental Hygiene  important: If item 27 is marked other than "natural", or items 23a or 28a-f show any  njury or other (raumatic event, the Medical Examiner mast he notified at once.                        | Be Completed by Funeral Director | Usual Residence of Decedent 10a State 10b. County Maryland Monto 10e. Street and Number 4908 Adrian St: 11. Marital Status 1 Never Married 2 M 2 M 3 Widowed 4 Div 15. Decedent's Education (Special Elementary/Secondary (0-12) 17. Father's Name (First, Middle Alejandro Cri 19a Informant's Name/Relation Pelaya Juica/ 20a Method of Disposition | 19b. 45  | 1  |                          |                          |                               |               |                     |             |                   |  |                              |                     |   |                |
| Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr  |                                  | 1 X Burial 2 Crematio 4 Donation 5 Other S 21 Signature of Funeral Service 23a. Part I. Enter the disease, of failure. List only one cause  | Epecify:  E Licensee  From complications on each line. | that caused the  | Gate<br>———              | Cem<br>22 No<br>Fr<br>50 | Heavetery<br>ame and<br>ancis | ddress of J.  | sity                | lins<br>Blv | Fune:             | ral<br>Sil                             | Home<br>ver S                | Inc.<br>pri         | ng, MD 2 Approximate In Between Onse          | 0901<br>terval |
| executed and transit al - transit   | ical Examiner                    | Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | Due to (c<br>b.<br>Due to (c<br>e c.                   | e Injuries or as a consequer or as a consequer or as a consequer | nce of):                 |                          |                               |               |                     |             |                   |  |                              |                     |   |                |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | Physician/Medical                | IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 U  | the 1 4  | f yes, outcome of<br>Live birth<br>Pregnant at time<br>Unknown   | 2                        |                          | tal death<br>her (Speci       | 3 [<br>ify)   | Ectopic             | ; pregna    | ncy               |  | 23d. Date of<br>Month        |                     | y<br>Day Yea                                  | ır             |
| ; P.O. B<br>ires that the di<br>signed by the<br>1 be detached  | þ                                | Part II. Other significant cond   | litions contrib  | uting to death but   | not resulting            | in the u                 | ınderlying                    | cause gi      | ven in Pa           | art I.      |                   |  |                              |                     | the cause of deat                             |                |
| of Vital Records, ing Physician: The law required After this certificate has been stuneral director, page 2 should  | plete                            |   |  |  |                          |                          |                               |               | <del></del>         |             | pe                | /as an<br>utopsy<br>erformed<br>es 2 ✓ | 1?                           | orior to death?     | stopsy findings av-<br>completion of causes 2 |                |
| The state of Death (Check only one)  25. Was case referred to medical examiner?  1  |                                  |   |  |  |                          |                          |                               |               |                     |             |                   |  |                              |                     |   |                |
| Vita<br>nysicia<br>this ca<br>direc   | 8                                | examiner?   |  | 1 / Inpatient  |                          | tpatient                 |                               | 31.           |                     |             | g Home 5          |  | idence 6                     | Othe                | r.  |                |
| n of<br>ing Pl<br>After<br>uneral   | ı.                               | 27. Manner of Death   | 1.   | a. Date of Injury<br>(Month, Day Year)<br>In 23, 2006            | 28b. T                   | ime of I<br>hrs          | njury 2                       |               | yat Work<br>'es 2 ✔ | . 1         |                   |  | injury occurr<br>d out of th |                     |   |                |
| ion<br>trendi<br>leath.   | atio                             | 5 PE  | estigation   |  | - 1                      |                          |                               |               |                     |             | 001 1             | /0/                                    |                              | D                   | uni Dauta Mumba                               | c City         |
| IVIS<br>or All<br>after d<br>Direc  | Iii                              | 3 V Suicide 6 Co  | build not be   | e. Place of Injury   |                          |                          |                               | опісе р       | ullaing, et         | IC.         | or Tow            | n, State                               | )                            |                     | ural Route Numbe                              |                |
| Divisior  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the.  | _                                | 4 Homicide  | Physician: To  | the best of my kn  | owledge dea              | th occu                  | rred at the                   | time, da      | ite and pla         | ace, and    | due to the d      | cause(s)                               | and manne                    | r as sta            | rted.<br>ne cause(s)                          |                |
| To the Hos within 24 h To the Fun Completely  | Medical                          | one) 2 Medical E  | and m  | anner stated   | ori qiratori II          |                          |                               |               | e number            |             |                   | 29                                     |                              | ed (Mo              | onth, Day, Year)                              |                |
|   |                                  | 30. Name and address of pers  | on who complet   | ed cause of death  | n (Item 23a)<br>niner 11 | I1 Per                   | n Stree                       | t, Balt       | imore,              | MD 21       | 201               |  | ·-··                         |                     |   |                |

32 Registrar's Signature

|                     |  | 4              | For<br>State<br>Registrar  | State of Maryla  | •                                     | artment of H<br>rtificate of L                         |  |  | giene<br>Reg. No. 20             | 06                        | 22612  |
|---------------------|--|----------------|--|--|---------------------------------------|--|--|--|----------------------------------|---------------------------|--|
|                     | Physicia   | an             | 1. Decedent's Name (First, Middle, Last) Shirley Doris John                            | eton   |                                       |  |  | 2. Date of Dea<br>Month                    | Day                              | Year                      | 3. Time of Death                                   |
| ,                   | /Medic<br>Examin   |                | 4a. Facility Name (If not institution, give s  |  |                                       | 4b. City, Town, or                                     | r Location of Death                      | June 25                                    | 4c. County                       | of Death                  | 11:00 p <sup>M</sup>                               |
|                     | CXUIIII  | Ų.             | Suburban Hospital  |  |                                       | Bethesda   |  |  | Montgo                           |                           |  |
|                     | Funeral<br>Director  |                |  | 7. Age (In y   | rs. last birthday)<br>Yrs.            | If Under 1 Year<br>Months Days                         | If Under 24 Hrs.<br>Hours Min.           | 8. Date of Birth<br>(Month, Day<br>Sept. 2 | /. Year)                         | 9. Birthp<br>Coun<br>Penr | lace (State or Foreign<br>htry)<br>1sylvania       |
|                     | land   |                | Usual Residence of Decedent  10a, State 10b, County                                    | 10c.   | City, Town or Lo                      | ocation  |  |  |                                  | 1                         | 0d. Inside City Limits                             |
|                     | Mary Mary  | tor            | Maryland Montgomer   | y Si   | lver Sp                               | ring   |  |  |                                  |                           | 1 ☐ Yes ¾QNo                                       |
|                     | or 28  | Director       | 10e. Street and Number   |  |                                       | 10f. Zip Code  |  |  | 10g. Citizen of W                | /hat Coun                 | ntry?  |
|                     | eeth v   | Funeral        | 3820 Palmira Lane  | 12. Was Decedent Ever in   | n U.S.   13                           | 20906<br>Was Decedent of H                             | ispanic Origin? (St                      |  | United S                         |                           | S Indian,  |
| 36                  | s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28a-f ehow other treumatic event, the Medical Exandrat must be notified at | by Fun         | 1 Never Married 2 Married 3 Widowed 4 Divorced   | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:                     |                                       | If Yes, specify Cuba<br>1 ☐ Yes 2 🛣 No                 | Specify:                                 | Rican, etc.)                               | Blac                             | k, White,<br>Whit         | etc.   |
| 2-0                 | 72 hou   | eted           | 15. Decedent's Educ<br>(Specify only highest grade                                     |  | (Give                                 | dent's Usual Occupa                                    | during most of work                      | king                                       | 16b. Kind of Bu                  | siness/Inc                | dustry   |
| 121                 | within<br>ane.<br>then   | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5+)   |                                       | DO NOT use retired<br>ceeper                           | 1)                                       |  | Construc                         | . 4. 4                    |  |
| 1d 2                | illed<br>Hygir<br>other  | BeCc           | 12<br>17. Father's Name (First, Middle, Last)  |  | - Booki                               | tecper   | 18. Mother's Nam                         | ne (First, Middle,                         |                                  |                           |  |
| ylar                | Menta<br>Menta<br>arked<br>atic ev   | To B           | Brooks E. King   |  |                                       | ng Address (Street                                     | Pearl Lu                                 | cy Crais                                   | 2                                |                           |  |
| Maryland 21215-0036 | 12 should hand 7 is m  |                | 19a. Informant's Name/Relationship (Type<br>Richard Johnston -                         |  |                                       |  |  |  |                                  |                           |  |
| <u>ē</u>            | Heelt<br>Heelt<br>Item 2   |                | 20a. Method of Disposition   | 20   | b. Place of Dispo                     | Palmira I<br>osition (Name of<br>matory or other place |  | ver Spri<br>Date                           | 20c. Location                    | 2090<br>City or To        | 6<br>wn, State                                     |
| m<br>0              | t. Pages 1<br>rtment of He<br>rtent: If iten   |                | 1 ☐ Burial 24 ☐ Cremation 3 ☐ R.<br>4 ☐ Donation ☐ ☐ Other (Specify)                   | emoval from State Fo   | ort Line                              | oln Crema  | atory 7-3                                |  | Brentwo                          | od,                       | MD   |
| Baltimore,          | permit. Pages 1 Department of H Importent: If ite eny Injury or of once.   |                | 21. Sign true of Funeral Service Licens  | - Mady   |                                       | 2. Name and Addres<br>Lke, Rocky                       |  |  | ibute, 1                         | 040                       | Rockville  |
|                     |  |                | 23a. Part1. Enter the disease, or complications, or heart failure. List only on        | cations that caused the die cause on each line.                              | eath. Do not en                       | ter the mode of dyin                                   | g, such as cardiac                       | or respiratory ari                         | rest,                            |                           | Approximate<br>Interval Between<br>Onset and Death |
| 1                   | Physician<br>/Medical  |                | Immediate Cause (Final disease or condition resulting in death)                        | Metastatic   |                                       | of Unknow  | vn Primar                                | у  |                                  |                           | Onser and Death                                    |
|                     | Examiner   |                |  | Due to (or as a con:   | sequence of):                         |  |  |  |                                  |                           |  |
|                     | D #  | ner            | Sequentially list conditions, if any, leading to intrinciplate cause. Enter Underlying | Due to (or se a con:   | sequance of).                         |  |  |  |                                  |                           |  |
|                     | and II-trans   | Examin         | Cause (Disease or injury that initiated events resulting in death) Last                | . Due to (or as a con:   | sequence of):                         |  |  |  |                                  |                           |  |
| 8760,               | cate be executed<br>physicien and<br>the burial-transit  | dical E        | L a  | `  |                                       |  |  |  |                                  |                           |  |
| 9                   | rtificat<br>ng phy<br>s as th  | Medi           | IF FEMALE:   |  |                                       | _  |  |  | I                                |                           |  |
| Вох                 | death certific<br>e ettending p<br>od for use as   | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?                                      | 3c. If yes, outcome of pre<br>1☐Live birth 2☐F<br>4☐Pregnant at time         | etal death 3                          | □Ectopic pregnancy<br>□ Other (specify)                | ,  |  | 23d. Date<br>Mor                 | e of delive<br>nth        | ory<br>Day Year                                    |
| P.O.                | at the de<br>by the e  | hysi           | 9 Unknown  | 9 Unknown  |                                       |  |  |  |                                  |                           |  |
| Vital Records, F    | signed<br>d be de  | þ              | Part II. Other significant conditions con Dementia                                     | tributing to death but not   | resulting in the L                    | Inderlying cause give                                  | en in Part I.                            |  |                                  | ibute to th               | ne cause of death? ably 4 □Unknown                 |
| eco                 | aw<br>2 sb   | Completed      |  |  |                                       |  |  | 24a. Was a                                 | sy p                             | Vere autor                | psy findings available impletion of cause of       |
| al R                |  |                |  |  |                                       |  |  | 1 ☐ Yes                                    | 2 X No 1                         | leath?                    | 2 No   |
| × ×                 | Physiclen:<br>rthis certific<br>ral director.  | o Be           | 25. Was case referred to medical examiner?  1 Yes 2 No                                 | lospital: 1 Inpatient  | 2 DER/Outpatie                        | nt 3 DOA Othe  | or                                       | th (Check only or<br>ome 5 ☐ Resid         |                                  | er (Snecifi               | v)   |
| on of               | Attending Phy ir death. ector: After thii by the funeral c   | ıtlon; T       | 27. Mapner of Death 1 ₾Natural 5 □ Pending 2 □ Accident investigation                  | 28a. Date of Injury<br>(Month, Day Year                                      | 28b. Time o                           | of 28c. Injun<br>World                                 | v at                                     | 28d. Describe h                            |                                  |                           |  |
| Division            | tal or Attending Pt<br>is efter death.<br>el Director: After the<br>ed in by the funeral   | Certification; | 3 Suicide 6 Could not be<br>4 Homicide determined                                      | 28e. Ptace of Injury - A building, etc. (Sp.                                 |                                       | reet, factory, office                                  |  | 28f. Location (S<br>City or Tow            | itreet and Numbern, State)       | or Rura                   | l Route Number,                                    |
|                     | Hospi<br>4 hour<br>Funer<br>ely fill   | edicai C       | 29a. Certifier 1 Certifying Physical Check only 2 Medical Examination                  | sician: To the best of my<br>ner: On the basis of exam<br>and manner stated. | knowledge, deat<br>nination and/or in | th occurred at the tin                                 | ne, date and place<br>pinion, death occu | , and due to the or<br>rred at the time, o | cause(s) and madate and place, a | nner as st<br>and due to  | ated.<br>the cause(s)                              |
|                     | To the I<br>within 2<br>To the I<br>complet  | Me             | 29b. Signature and this of certifier   |  |                                       | 29c. License   |  | i  | 29d. Date signed                 | (Month, )                 | Day, Year)   |
| •                   | 2  |                |  |  |                                       |  | 061302                                   |  | 6/26/06                          | J.                        |  |
|                     |  |                | 30. Name and address it person who co  |  |                                       |  |  |  | 1 (                              |                           |  |
|                     | Sta  | ite            | Atul Rohatgi, MD 9 31. Date filed (Month, Day, Year)                                   | 32. Rigistrar's Si   | Center<br>ignature                    | Drive, Ro  | ockville,                                | MD 2080                                    | )5                               |                           |  |
|                     | Registr  |                | JUN 3 0 2  | 006 Again  | 15 P                                  | Control  |  |  |                                  |                           |  |

Shirley Johnston June 25, 12000

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1:10 PM Dorothy Thompson Kaetzel 2006 29 <u>June</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Berlin Nursing & Rehabilitation Ctr. Berlin Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan.7, 1927 6. Sex **Funeral** Months Washington, DC 1 □ M 2 X F 578-30-2184 Director 79 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County ir than "natural", or Itams 23a or 28a-f show the Medical Exporter nust be notified at 1 ☐ Yes 2 XNo Director Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 Lark Lane #203 21842 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Agent Real Estate is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert Thompson Pauline Strobel 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itam 27 i 15776 Leslie St., Aurora, Ontario L4G7C4 Dale Alan Kaetzel 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cheltenham Vet. Cem. 07/12/2006 Cheltenham, Md. Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If it any injury or o 1 Neurial 2 Cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, Ma. 21811 2 a. Part1. Enter thic sease, or complication shock, or heart in lure. List only of Po not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Slibblastoma Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease on injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Nuknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ormed2 2 4 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Diractor; After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature 209 Coorfel Veglang Fewick Molo-32. Pegistrar's Signature 31. Date filed (Month, Day. Year) State JUL 0 5 2006 Registrar

DHMH 17 Rev 1/200

Dorothy

Kaetzel,

|                            |   |                | State of Maryland   |                             | rtment of He   |  |  | ZUUt                                    | 22614                                       |
|----------------------------|---|----------------|---|-----------------------------|--|--|--|---|---|
|                            |   |                | Registrar  1. Decedent's Name (First, Middle, Last)   | Cei                         | uncate of L  |  | Reg. No.                                       |   | 3. Time of Death                            |
| Н                          | Physicia<br>/Medic  |                | Doris Pauline KIBLER  |                             |  |  | July 4   | 2 2 × 2 × 2 × 2 × 2 × 2 × 2 × 2 × 2 × 2 | 0 313 P.M                                   |
|                            | Examin  |                | 4a. Facility Name (If not institution, give street and number)  |                             | 4b. City, Town, or l   |  | 40   | c. County of Dea                        |   |
| 1                          | Funeral   |                | Washington County Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last   | t birthday)                 | Hagerst<br>If Under 1 Year   | If Under 24 Hrs.                             | B. Date of Birth                               | Washin                                  | thplece (State or Foreign                   |
|                            | Director  |                | 216-14-5268 1□M 2ÑF 82  | Yrs.                        | Months Days  | Hours Min. O                                 | (Month, Day, Year<br>ct. 4 192                 |   | ountry)<br>ryland                           |
|                            | and   |                | Usual Residence of Decedent           10a, State         10b, County         10c, City, T   | own or Loc                  | cation   |  |  |   | 10d. Inside City Limits                     |
|                            | Mary<br>I-f sho   | tor            | Maryland Washington Hag   | ersto                       | wn   |  |  |   | 1X Yes 2 □ No                               |
| :                          | or 284  | Director       | 10e. Street and Number  |                             | 10f. Zip Code  |  | 10g. C   | itizen of What C                        | ountry?                                     |
|                            | 18 23a  |                | 1175 Professional Court  11 Marital Status 12. Was Decedent Ever in U.S.  | 13 V                        | 2174   |  | ify Yes or No-                                 | USA<br>14. Race - Am                    | erican Indian                               |
|                            | riter of  | Funeral        | Armed Forces?  1 Never Married 2 Married 1 Yes 2 N No   | 1                           |  | panic Origin? (Spec<br>, Mexican, Puerto R   | ican, etc.)                                    | Black, Whi                              |   |
| Maryland 21215-0036        | 2 should be filed within 72 hours after death with free Maryland and Mental Hygiene. Is marked other then "natural", or items 23a or 28a-f show aumatic event, the Madical Examiner must be nutified at   | d by           | 3 ☐ Widowed 4 反 Divorced If Yes, Give Year or Dates:  |                             | Yes 2X No  | Specify:                                     |  |   | nite  |
| 15-                        | n 72 n<br>n natu  | Completed      | (Specify only highest grade completed)  | (Give I                     | ent's Usual Occupat<br>kind of work done du<br>DO NOT use retired) | uring most of workin                         | g 16b. (                                       | Kind of Business                        | /Industry                                   |
| 212                        | d withi   | omo            | Elementary/Secondary (0-12) College (1-4or 5+) 12 0 A   | dmini                       | strative   | Assistant                                    | :  | Phone C                                 | ompany                                      |
| פ                          | be filed<br>htal Hygi<br>d other<br>event, I  | Be C           | 17. Father's Name (First, Middle, Last)   |                             |  | 18. Mother's Name                            | (First, Middle, Maide                          | n Sumame)                               |   |
| Za                         | should the | ٦              | John S. Hess  | 10b M-III-                  |  |  | Whitting Route Number, City                    |   | Tin Code)                                   |
| Ma                         | 5 5 E E   |                |   |                             |  |  | lagerstown                                     |   | G7. //                                      |
| ē,                         | of Head of Item   |                | 20a. Method of Disposition 20b. Plac  | e of Dispos                 | sition (Name of<br>natory or other place                           | Da   |  | ocation - City or                       |   |
| altimore,                  | y or  |                | 1 M Burial 2 Cremation 3 Hemoval from State   |                             | Cemetery   |  | Hag  | erstown                                 | , Maryland                                  |
| Bait                       | permit. I<br>Departm<br>Importat<br>any Inju  |                | 21. Signature of Funeral Service Licensee   |                             | . Name and Address   |  | linnich Fu                                     |   |   |
|                            | 401 # G   | Щ              | 23a. Part 1. Enter the disease, or complications that caused the death.   |                             |  |  | Hagersto respiratory arrest,                   | wn, Md.                                 | Approximate                                 |
| F                          | Physician   |                | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition   | lunder                      | aus A  | (ve) t                                       |  |   | Interval Between<br>Onset and Death         |
|                            | /Medical  |                | disease or condition resulting in death)  a.   Due to (or as a consequent of the control of the |                             | 1  | 11   |  |   |   |
|                            | Examiner  | <u>.</u>       | Sequentially list conditions, france leading to immediate   | 21                          | latare   | tich   |  |   |   |
|                            | nsit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events  | ice ory.                    |  |  |  |   |   |
| oʻ                         | te be executed<br>ysicien and<br>e burial-transit   |                | resulting in death) Last  Due to (or as a consequent  | nce of):                    |  |  |  |   |   |
|                            | ₩ × × ∞   | lical          | d   |                             |  |  |  |   |   |
| × 68                       | The law requires that the death certifica iste has been signed by the attending phage 2 should be detached for use as the   | Physician/Med  | IF FEMALE: 23c. If yes, outcome of pregnance  | v                           |  |  |  | 23d. Date of de                         | livon                                       |
| Bo                         | death<br>atten<br>d for u   | ician          | 23b. Was decedent pregnant in the past 12 months? 1 Vec 2 No. 4 Pregnant at time of deat  | ath 3                       | Ectopic pregnancy Other (specify)                                  |  |  | Month                                   | Day Year                                    |
| P.O. Box                   | that the de<br>led by the a<br>detached f   | hys            | 9 ☐ Unknown   |                             |  |  |  |   | -   |
| s,                         | ires tha<br>signed<br>t be del  | þ              | Part II. Other significant conditions contributing to death but not resulting   | ng in the ur                | nderlying cause give   | n in Part I.                                 | 23e. Did tobacco                               |   | o the cause of death?<br>robably 4 □Unknown |
| Š                          | w require<br>been sig<br>should b   | Completed      |   | _                           |  |  | 24a. Was an                                    |   | utopsy findings available                   |
| Re                         | The law<br>sete has l<br>page 2 s   | dmo            |   |                             |  |  | autopsy<br>performed?                          | prior to death?                         | completion of cause of                      |
| Ita                        |   | Be C           | 25. Was case referred to medical examiner?  |                             |  | 26. Place of Death                           |  | 0 10.                                   | 20,10                                       |
| Division of Vital Records, | tending Physician:<br>leath.<br>tor: After this certifice<br>the funeral director, i  | ဥ              | 1 ☐ Yes 2 ☑ No Hospitat: 1 ☑ Inpatient 2 ☐ ER   |                             | t 3 DOA Othe   | 4   Nursing nom                              | e 5 Residence                                  |   | ecify)                                      |
| ou                         | ding<br>Afte<br>fune  | Certification: | 27. Manner of Death  1  | Bb. Time of<br>Injury       | 28c. Injury<br>Work'<br>M 1 □ Y                                    | at<br>?<br>'es 2 □ No                        | 8d. Describe how inj                           | ury occurred                            |   |
| <u>Visi</u>                | or Attending<br>after death.<br>Director: Afte<br>in by the fune  | Ifica          | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)   | e, farm, stre               | eet, factory, office   | 2  | Bf. Location (Street a<br>City or Town, Sta    | and Number or A                         | Bural Route Number,                         |
| Ö                          | ital or<br>irs afte<br>ral Dir<br>led in  |                |   |                             |  |  |  |   |   |
|                            | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by  | edical         | 29a. Certifier 1 Certifying Physicien: To the best of my knowle (Check only one) Medical Exeminer: On the basis of examination and manner stated.   | edge, death<br>n and/or inv | occurred at the time<br>restigation, in my op                      | e, date and place, a<br>inion, death occurre | nd due to the cause(<br>d at the time, date ar | s) and manner a<br>nd place, and du     | s stated.<br>e to the cause(s)              |
|                            | To the within 2 To the complet  | Med            | 29b. Signature and title of certifier   |                             | 29c. License   | number                                       | 29d. D   | ate signed (Mon                         | th, Day, Year)                              |
| )                          | 0   |                | The Ol  |                             | D5   | 8267   | 7  | -6-0                                    | 16  |
| 100 E                      | n a   |                | 30. Name and address of person who completed cause of death (Item 2   | 3a) (Type, i                | Print)   |  | / //   | ma l                                    | 2.5.  |
| ÞΗ                         | -↓<br>Sta   | t c            | 31. Date filed (Month, Day, Year) 32. Registrar's Signatur  | rea                         | leal la  | mpies R                                      | d Hry  | /rld .                                  | <1.140                                      |
| 1                          | Regist  |                | JUL 0 7 2006  | 9. 1                        | E market   |  |  |   |   |

|                     |   |                     | For<br>Stete<br>Registrar   | State of Ma  | ryland / Dep<br><i>Ce</i>            |                                 | of Health a<br>of Death                                   | ind Me        |                               | giene<br>leg. No.            | 006                            | 22615  |
|---------------------|---|---------------------|---|--|--------------------------------------|---------------------------------|---|---------------|-------------------------------|------------------------------|--------------------------------|--|
|                     | Physici   | an                  | 1. Decedent's Name (First, Middle, La   |  | THEL KEE                             | FER                             |   |               | Date of Dea<br>Month          | Day                          | 2006                           | 3. Time of Death                                   |
|                     | /Medic<br>Examin  |                     | 4a. Facility Name (If not institution, giv  | e street and number)   |                                      | 4b. City, T                     | own, or Location of                                       |               | July                          |                              | inty of Death                  |  |
|                     | Examili   | ei<br>S             | Carroll Hospital  |  |                                      | West                            | minster   |               |                               | Carı                         | coll C                         | ountv  |
| et*                 | Funeral   | 7.24                | 5. Social Security Number 6. S  | Sex 7. Age   | (In yrs. last birthday,              |                                 | Year If Under 2<br>Days Hours                             | Min.          | Date of Birtl<br>(Month, Day  | Year)                        | 9. Birth                       | place (State or Foreign<br>ntry)                   |
| 0                   | Director  |                     | 215–26–1289 Usual Residence of Decedent   | A  | 89 Yrs.                              |                                 |   | A             | pr. 8,                        | 1917                         | Mary                           | Tand   |
|                     | yland<br>yland  |                     | 10a. State 10b. County  |  | 10c. City, Town or L                 |                                 |   |               |                               |                              |                                | 10d. Inside City Limits                            |
|                     | death with the Maryland<br>ms 23a or 28a-f show<br>rmust be notified at   | ctor                | Maryland Carroll  | County   | Taneyt                               | COWLI                           |   |               |                               |                              |                                | 1 XYes 2 ☐ No                                      |
| 2                   | ith th  | Dire                | 10e. Street and Number  | D 3  |                                      | 10f. Zip (                      |   |               |                               |                              | of What Cou                    | •  |
| <u>\$</u>           | eath v  | erai                | 325 Roberts Mill  | 12. Was Decedent E   | ver in U.S. 13.                      |                                 | 21787   | in? (Specif   |                               |                              | d Stat                         |  |
| JERMA<br>36         | or ite  | by Funeral Director | 1 Never Married 2 Married 3 Widowed 4 Divorced  | Armed Forces?  1  Yes 2 XNo If Yes, Give Year or Dates:              |                                      | If Yes, specif                  | ent of Hispanic Orig<br>by Cuban, Mexican,<br>No Specify: | , Puerto Rio  | ćan, etc.)                    | - 1                          | Black, White,                  |  |
| $CCK_{\perp}$ $Dt$  | n 72 hours<br>"natural",<br>edice Exe   |                     | 15. Decedent's E  | ducation   | 16a. Dece                            | edent's Usual                   | Occupation  |               |                               | 16b, Kind o                  | of Business/In                 | ndustry  |
| 7 515               |   | Completed           | (Specify only highest gri<br>Elementary/Secondary (0-12)  | ade completed)  College (1-4or 5+                                    | -)                                   |                                 | done during most<br>retired)                              | of working    |                               |                              |                                |  |
| 2 2                 | 0 0 0   | Con                 | 10  |  | h                                    | omemak                          |   |               |                               |                              | home                           |  |
| KEE!                | 0 0 0   | Be                  | 17. Father's Name (First, Middle, Last John Fleming   | )  |                                      |                                 |   | ,             | First, Middle,<br>Blaxste     |                              | name)                          |  |
| Z Z                 | 2 should be to and Mental I is marked or raumatic svs   | <sup>L</sup>        | 19a. Informant's Name/Relationship (  | Type, Print)   | 19b. Mail                            | ing Address (                   | Street and Number   | r or Rural F  | Route Numbe                   | r, City or To                | wn, State, Zij                 | o Code)  |
|                     | alth ar   |                     | Nancy L. Keefer   | / daughter   | 32                                   | 5 Robe                          | rts Mill  | Road          | Tark                          | eytown                       | , Mary                         | land 21787   |
| ore,                | of Head   |                     | 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐  | Domoval from State   | 20b. Place of Disp<br>cemetery, cre  |                                 |   | uly Dat       | 14                            | 20c. Location                | on - City or T                 | own, State   |
| 3altimore,          | ment<br>ment<br>tant: I   |                     | 4 Donation 5 Other (Speci   |  | Pipe Cre                             |                                 | netery  | 20            | 06                            |                              | •                              | Maryland   |
| Balt                | permit. Pages 1 and 2 should the permit. Pages 1 and 2 should the permit of Health and Menimportent: If item 27 is marker sny injury or other traumatic 1 ance.                                   |                     | 21. Signature of Funeral Service Lice   | Lever  | 1                                    | 36 Eas                          | Address of Facility St Baltime                            | Skil<br>ore S | es Fun<br>treet               | eral I<br>Taney              | Home<br>ytown,                 | Md. 21787  |
| 45                  |   |                     | 23a. Part1. Enter the disease, or comshock, or heart failure. List only                                     | one cause on each line   | A                                    |                                 |   | cardiac or r  | espiratory ar                 | rest,                        |                                | Approximate<br>Interval Between<br>Onset and Death |
|                     | Pnysician   |                     | Immediate Cause (Final disease or condition resulting in death)   | a  | este 1                               | M                               |   |               |                               |                              |                                | Offset and Death                                   |
|                     | /Medical<br>Examiner  |                     | resulting in dealth)  | Due to (or as a  | CSE 1 consequence of):               | / A.                            | 11151   |               |                               |                              |                                |  |
|                     | . *   | Jer                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury |  | consequence of):                     | 717                             | colo j.   |               |                               |                              |                                |  |
| V                   | sate be executed by sicien and the burial-transit   | Examiner            | that initiated events   | c  | CAD                                  |                                 |   |               |                               |                              |                                |  |
| 60,                 | oe exe  | EX                  | resulting in death) Last  | Due to (or as a  | consequence of):                     |                                 |   |               |                               |                              |                                |  |
| 09289               | <u>a</u> € €  | dical               | •   | d  |                                      |                                 |   |               |                               |                              |                                |  |
| Box (               | eath certific<br>attending p  | Physician/Me        | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of  |                                      |                                 |   |               |                               | 23d.                         | Date of deliv                  | ery  |
| œ.                  | death   | sicia               | in the past 12 months?<br>1 ☐ Yes 2 M No  | 1 ☐ Live birth 2<br>4 ☐ Pregnant at t<br>9 ☐ Unknown                 |                                      | □Ectopic pre<br>□ Other (spe    |   |               |                               |                              | Month                          | Day Year   |
| 0.0                 | that the de<br>led by the a   | Phys                | 9 Unknown   |  | A mad annualism in the               |                                 | in Death  |               | 220 Did to                    | bacca use o                  | estábuta ta t                  | the cause of death?                                |
| Vital Records, P.O. | Attending Physicien: The law requires that the death certific reath. sctor: After this certificate has been signed by the attending py the funeral director, page 2 should be detached for use as | ۵                   | Part II. Dther significant conditions   | contributing to death bu   | t not resulting in the               | underlying ca                   | use given in Fart i.                                      |               | 171                           |                              | o 3 Pro                        | N.4  |
| e<br>CO             | as bee  | Completed           |   |  |                                      |                                 |   |               | 24a. Was autop                |                              | 4b. Were auto                  | opsy findings available                            |
| <u>=</u>            | The<br>cate h<br>page   | Con                 |   |  |                                      |                                 |   |               | perfor                        | med?<br>2 No                 | death?<br>1 ☐ Yes              | 2□ No  |
| Vita                | sician: The law<br>certificate has l<br>irector, page 2 s   | Be                  | 25. Was case referred to medical examiner?  | Hospital:  |                                      |                                 | Other   |               | Check only o                  |                              |                                |  |
| ō                   | Phys<br>r this<br>ral dir   | To                  | 1 Yes 2 No 27. Manner of Death  | Hospital: 1 Impatier<br>28a. Date of Injun<br>(Month, Day            |                                      |                                 | 4 190   |               | d. Describe h                 |                              | Other (Speci                   | <i>fy</i> )  |
| - no                | nding I<br>ith.<br>:: After<br>e funer  | ation               | 1 Natural 5 Pending<br>2 Accident investigation   |  | Year) Injury                         | м                               | lc. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ N                   | No            |                               |                              |                                |  |
| ,<br>Division       | l or Attendi<br>after death.<br>Dirsctor: A<br>i in by the fu   | Certification:      | 3 Suicide 6 Could not to determined   |  | ry - At home, farm, s<br>. (Specify) | treet, factory,                 | office  | 28            | f. Location (S<br>City or Tow |                              | umber or Rur                   | al Route Number,                                   |
|                     | Hospita<br>24 hours<br>Funeral<br>tely filled   | Medical C           | 29a. Certifier 1 Certifying P   | hysician: To the best o<br>miner: On the basis of<br>and manner stat | examination and/or i                 | ith occurred a<br>nvestigation, | it the time, date and<br>in my opinion, deat              | d place, and  | d due to the o                | cause(s) and<br>date and pla | d manner as s<br>ce, and due t | stated.<br>to the cause(s)                         |
|                     | To the<br>Within 2<br>To the<br>comple  | Mec                 | 29b. Signature and title of certifie  |  |                                      | 29c.                            | License number  |               | ;                             | 29d. Date sig                | gned (Month,                   | Dey, Year)   |
|                     | F > F 0   |                     | 100   |  |                                      | #                               | 00394   | 147           |                               | 07/                          | 11/01                          | 5  |
|                     | ١.  |                     | 30. Name and address of person who  | completed cause of de  | eath (Item 23a) (Type                |                                 |   |               |                               | 1/                           | 1                              | 21157  |
|                     | V   |                     | SCOTT JER   | SMO  | 410 MA                               | Leoli                           | n DRIV  | 36            | WES                           | STMI                         | NSTE                           | rmo  |
|                     | Sta<br>Regist   | ate                 | 31. Date filed (Month, Day, Year)   | 2006 32. egistra   | r's Signatur                         | parti                           |   |               |                               |                              |                                |  |

|                     |  |                | _ POr   | artment of Health and Martificate of Death  |                           | iene 2006                                | 22616   |
|---------------------|--|----------------|---|---|---------------------------|--|---|
|                     | Physicia   | an             | 1. Decedent's Name (First, Middle, Last)  |   | 2. Date of Death<br>Month | Day Year                                 | 3. Time of Death                              |
|                     | /Medic   | -              | Antoinette Charlotte Ketels   |   | June 15                   |  | 7:10 P M                                      |
| P.                  | Examin   | er             | 4a. Facility Name (If not institution, give street and number)  | 4b. City, Town, or Location of Death  |                           | 4c. County of Death                      |   |
|                     | Function   |                | The National Lutheran Home  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday  | Rockville    If Under 1 Year   If Under 24 Hrs.                                   | 8. Date of Birth          | Montgomer<br>9. Birth                    | place (State or Foreign ontry)                |
|                     | Funeral<br>Director  |                | 148-56-4892 1□M 2X□F 88 Yrs.  | Months Days Hours Min.  | (Month, Day, Oct. 4,      |  |   |
|                     | nd ,   |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  |   |                           |  | 10d. Inside City Limits                       |
|                     | shov   | Į.             |   |   |                           |  | 1 G Yes 2 □ No                                |
|                     | 28a-i  | Directo        | Maryland Montgomery Rockvill  10e. Street and Number  | .e<br>10f. Zip Code   | 10                        | 0g. Citizen of What Cou                  |   |
|                     | 3a or  |                | 9701 Viers Drive  | 20850   |                           | U.S.A.                                   |   |
|                     | death  | Funeral        |   | Was Decedent of Hispanic Origin? (Spe<br>If Yes, specify Cuban, Mexican, Puerto F | cify Yes or No-           | 14. Race - Ameri<br>Black, White         |   |
| 98                  | or Ite   |                | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No If Yes, Give   | 1 ☐ Yes 2 ☑ No Specify:   |                           | Specify: Whi                             |   |
| Ö                   | be filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene. do chtar than "natural", or terms 23a or 28a-f show avant, I to Medical Examinar must to notified at | ed by          | 3   | édent's Usual Occupation  |                           | 16b. Kind of Business/Ir                 |   |
| 7                   | in 72<br>n "nai  | Completed      | (Specify only highest grade completed) (Giv   | e kind of work done during most of workir<br>DO NOT use retired)                  | ng                        | TOD. KING OF BUSINESSYN                  | dustry  |
| 212                 | e filed within al Hygiene. i other than "  | mo             | Elementary/Secondary (0-12) College (1-4or 5+) 12 Hom   | nemaker   | F                         | Private                                  |   |
| nd                  | e filed<br>al Hygi<br>i othar<br>vant, I   | Bec            | 17. Father's Name (First, Middle, Last)   | 18. Mother's Name   | (First, Middle, M         | Maiden Sumame)                           |   |
| yla                 | 2 should be to and Mental I is marked or raumatic ava  | To             | Frederick Staaterman  | Frieda  |                           |  |   |
| Maryland 21215-0036 | 12 sh<br>h and<br>7 is m<br>rsum   | 8 8            |   | ling Address (Street and Number or Rura   |                           |  |   |
| 45                  | es 1 and 2 should b<br>of Health and Menti<br>I itam 27 is marked<br>ir other traumatic a  |                | 20a Method of Disposition 20b. Place of Disp  | Woodland Dr. NW Wa  | ate 2                     | on, DC 2000<br>20c. Location - City or T |   |
| Baltimore,          | permit. Pages 1 Department of H Important: If its any injury or of   |                | 1√ Burial 2 □ Cremation 3 □ Removal from State George W   | ashington June 2  | 22,                       |  |   |
| Ħ                   | artme<br>ortan<br>injuri   |                | Memorial  | Park 22. Name and Address of Facility Jose  | 2006<br>eph Gawl          | Paramus, Ne<br>er s Sons,                | Inc.,   |
| B                   | Depa<br>Impo<br>any is   |                |   | 130 Wisconsin Ave.  | NW Wash                   | nington, DC                              | 20016   |
|                     |  |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.                       | nter the mode of dying, such as cardiac or  | respiratory arre          | est,                                     | Approximate<br>Interval Between               |
| E                   | Physician  |                | Immediate Cause (Final disease or condition Me # cfs # 12   | breast can  | . 45                      | 3  | Onset and Death                               |
|                     | /Medical<br>Examiner   |                | resulting in death)  Due to (or as a consequence of):   |   |                           |  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,       |
| H                   |  | 7              | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of).  |   |                           |  |   |
|                     | uted<br>I<br>Insit   | Examine        | cause. Enter Underlying Cause (Disease or injury  |   |                           |  |   |
| ó                   | be executed<br>sician and<br>burial-transit  |                | that initiated events c.  resulting in death) Last  Due to (or as a consequence of):  |   |                           | - 4                                      |   |
| 8760,               | death certificate be executed<br>e attending physician and<br>d for use as the burial-transit  | dical          | d   |   |                           |  |   |
| 9                   | artifica<br>ing ph<br>e as t   | Med            | IF FEMALE:  |   |                           |  |   |
| Вох                 | eath certific<br>attending p   | Physician/Med  | 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3   | □Ectopic pregnancy  |                           | 23d. Date of deliv<br>Month              | ery<br>Day Year                               |
| o.                  | t the de<br>by the a<br>tached t   | ysic           | 1 Yes 2 No 9 Unknown 5  | Other (specify)   |                           |  |   |
| ٦.                  | de de  |                | Part II. Other significant conditions contributing to death but not resulting in the  | underlying cause given in Part I.   | 23e. Did tob              | pacco use contribute to t                | the cause of death?                           |
| rds,                | quires<br>in sign<br>uld be  | ed by          | congestive heart fai  | 1014  | 1 ☐ Ye                    | s 2 No 3 Pro                             | bably 4 □Unknown                              |
| Vital Record        | > 0 50   | Completed      | Dementic  |   | 24a. Was ar               |  | opsy findings available ompletion of cause of |
| H.                  | 9 4 9  | mo:            |   |   | perform                   |  |   |
| /ita                | ician: Th<br>certificate<br>rector, pag  | Be             | 25. Was case referred to medical examiner?  | 26. Place of Death  | (Check only one           | 8)                                       |   |
| of \                | shys<br>this<br>al dii   | 은              | 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie   |   |                           | nce 6 Other (Speci                       | fy)   |
|                     | fter<br>ne   | tion           | 1 Satural 5 ☐ Pending (Month, Day Year) Injury  | of 28c. Injury at 2<br>Work?<br>M 1 ☐ Yes 2 ☐ No                                  | .ad. Describe no          | w injury occurred                        |   |
| Division            | Attanding r death. actor: After by the fune  | fical          | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s  |   | t8f. Location (Str        | reet and Number or Run                   | al Route Number,                              |
| D                   | i Pitte  | Certification: | 4 Homicide determined building, etc. (Specify)  | ·   | City or Town              | , State)                                 |   |
|                     | Hospit<br>4 hour<br>Funari   | edical (       | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated. |   |                           |  |   |
|                     | To the Hos within 24 hor To the Fun Completely   | Me             |   | 29c. License number   | 29                        | 9d. Date signed (Month,                  | Day, Year)                                    |
|                     |  |                | 1 Smaller 11  | n Doo506/2  |                           | Jun. 16.                                 | 2006  |
|                     | 5  |                | 30. Name and address of person who completed cause of death (Item 23a) (Type  | e, Print)   | A 1A                      | C  | NA  |
|                     |  |                | SAMUEL G. MALLER MI   | 3305 N. LEISURE W   | (1) BLVI                  | ) SILLELLY.                              | 20906   |
|                     | Sta<br>Registi   |                | 31. Date filed (Month, Day, Year)  32 Registrar's Signature   | 29c. License number  DO 0506/2  Print)  A ST N LEISURE W                          |                           |  |   |

|            |   |                  | 1 - For<br>State<br>Registrar   | State of Ma  | aryland / L        |                  | tificate o   |                            |                               |                                | gierie Z. ()<br>Reg. No.           | Ub                       | 2.6                                     | 61/        |
|------------|---|------------------|---|--|--------------------|------------------|--|----------------------------|-------------------------------|--------------------------------|------------------------------------|--------------------------|---|------------|
|            |   |                  | Decedent's Name (First, Middle, Last  | st)  |                    |                  |  |                            |                               | 2. Date of De.<br>Month        | ath<br>Day                         | Year                     | 3. Time of                              | Death      |
|            | Physici<br>/Medic   |                  | Henry Edwa  | ard  | Kell               | У, З             | Jr.  |                            |                               | June                           | 28, 200                            |                          | 6:30                                    | рм         |
| 1          | Examin  |                  | 4a. Facility Name (If not institution, give   | street and number)   |                    |                  | 4b. City, Town   |                            |                               |                                | 4c. County                         |                          |   |            |
| 1          |   |                  | Hillhaven Nursin  | ng Center,   | Inc.               |                  |  | delph:                     |                               |                                | Prince                             |                          |   |            |
|            | Funeral   |                  | 5. Social Security Number 6. S  | ex 7. Age  | (In yrs. last bir  | thday)<br>Yrs.   | If Under 1 Yes<br>Months Day                           |                            |                               | 8. Date of Bird<br>(Month, Da  | y, Year)                           |                          | place (State ontry)                     |            |
|            | Director  |                  | 579-18-5113 Usual Residence of Decedent   |  | 84                 |                  |  |                            |                               | June 27                        | , 1922                             | Wash                     | ningto                                  | n, DC      |
|            | yland   |                  | 10a. State 10b. County  |  | 10c. City, Tow     | n or Lo          | cation   |                            |                               |                                |                                    | 1                        | 10d. Inside C                           | ity Limits |
|            | within 72 hours after death with the Maryland<br>ene.<br>then "naturel", or items 23a or 28a-f ehow<br>he Madical Exeminer nust be mutified at  | Funeral Director | Maryland Montgor  | nery   | Silve              | r Sı             | oring  |                            |                               |                                |                                    |                          | 1 🗆 Yes                                 | 2 K X10    |
|            | or 28   | Oire.            | 10e. Street and Number  | _  |                    |                  | 10f. Zip Code  | •                          |                               |                                | 10g. Citizen of \                  | What Cour                | ntry?                                   |            |
|            | ath w   | ral              | 703 Horton Drive  | 1  |                    |                  |  | 902                        |                               |                                |                                    | JSA                      |   |            |
|            | tems  | une              | 11. Marital Status  | 12. Was Decedent 8<br>Armed Forces?                                  |                    | 13. V            | Vas Decedent of<br>Yes, specify C                      | f Hispanic<br>uban, Mexi   | Origin? (Spe<br>can, Puerto l | cify Yes or No<br>Rican, etc.) | - 14. Rac                          | e - Americ<br>ck, White, | can Indian,<br>etc.                     |            |
| 36         | rs afte   | by F             | 1 ☐ Never Married 2 🔀 Married<br>3 ☐ Widowed 4 ☐ Divorced   | 1 TYes 2 □ N<br>If Yes, Give<br>Year or Dates: 1                     | 10<br>11117 T T    | 1                | □Yes 25k   | lo Spec                    | ify:                          |                                | Specify                            | Whi                      | te                                      |            |
| 21215-0036 | 2 hou   | pe               | 15. Decedent's Ed   | ducation   |                    | Deced            | lent's Usual Occ                                       | upation                    |                               |                                | 16b. Kind of B                     | usiness/In               | dustry                                  |            |
| 215        | hin 72  | ple              | (Specify only highest gra   | de completed) College (1-4or 5                                       | +)                 | (Give<br>life. [ | lent's Usual Occ<br>kind of work dor<br>OO NOT use ret | ne during ri<br>ired)      | ost of workit                 | n <i>g</i>                     |                                    |                          |   |            |
| 21         | or the  | Completed        |   | 2  |                    | arma             | aceutica   |                            |                               |                                |                                    |                          | mpany                                   |            |
| Maryland   | be fill   | Be               | 17. Father's Name (First, Middle, Last)   |  |                    |                  |  |                            |                               |                                | , Maiden Suman                     |                          |   |            |
| 3          | d Mer<br>narke  | 2                | Henry Edward Ke   |  | 106                | Mailin           | a Address /Stra  |                            |                               |                                | eline Ha<br>er, City or Town,      |                          |   |            |
| Z          | d 2 si<br>th an<br>t7 ie r<br>traur   |                  | Anne F. Kelly/ W:   | , ,  |                    |                  | _  |                            |                               |                                | ng, MD 2                           |                          |   |            |
| ā,         | Heal<br>Heal<br>tem 2   |                  | 20a. Method of Disposition  |  | 20b. Place o       | f Dispo          | sition (Name of<br>natory or other p                   |                            |                               | ate                            | 20c. Location -                    |                          |   |            |
| Ë          | Page ento   |                  | 1  Burial 2  Cremation 3  C<br>4  Donation 5  Other (Specifi  | Removal from State   |                    |                  | aven Ceme  |                            | July                          | 06                             | Silver                             | Spri                     | na Ma                                   | rulan      |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f show mary injury or other traumatic event, the Madical Examinatory is the notified at once.                               |                  | 21. Signature of Funeral Service Licer  | 1500   |                    | 22               | Name and Add   | ress of Fa                 |                               |                                | l Home I                           |                          | ng, na                                  | r y ran    |
| <u> </u>   | 88 5 8  |                  | James 5   | John   |                    | 50               | O Unive  | reit                       | z Blud                        | W S                            | ilver Sr                           |                          |   |            |
|            |   |                  | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only   | plications that caused<br>one cause on each lin                      | the death. Do      | not ente         | er the mode of d                                       | ying, such                 | as cardiac o                  | r respiratory ai               | rrest,                             |                          | Approximat<br>Interval Bet<br>Onset and | ween       |
| 1          | Physician /Medical  |                  | Immediate Cause (Final disease or condition resulting in death)   | a Sepsis   |                    |                  |  |                            |                               |                                |                                    |                          | 1_Da                                    |            |
|            | Examiner  |                  |   | Due to (or as a Gangrene   | a consequence      |                  |  |                            |                               |                                |                                    |                          | l We                                    | o.le       |
|            |   | er               | Sequentially list conditions, if any, leading to immediate  | D  | a consequence      |                  | .000   |                            |                               |                                |                                    |                          | T 146                                   |            |
|            | cuted   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | <sub>c</sub> Periphera   | al Vasc            | ular             | Diseas   | se                         |                               |                                |                                    |                          | 1 We                                    | ek         |
| 0,         | e exe<br>ian ar<br>urial-t  |                  | resulting in death) Last  | Due to (or as a  | a consequence      | of):             |  |                            |                               |                                |                                    |                          |   |            |
| 68760,     | eath certificate be executed<br>attending physician and<br>for use as the burial-transit  | edicai           | •   | d  |                    |                  |  |                            |                               |                                |                                    |                          |   |            |
|            | ding p  |                  | IF FEMALE:  | 23c. If yes, outcome   | of pregnancy       |                  |  |                            |                               |                                | 22d De                             | to of delia              |   |            |
| Вох        | atten<br>atten<br>I for u   | cian             | 23b. Was decedent pregnant<br>in the past 12 months?  | 1☐Live birth<br>4☐Pregnant at  | 2 Fetal death      |                  | Ectopic pregnal<br>Other (specify)                     |                            |                               |                                |                                    | te of delive<br>inth     | •                                       | Year       |
| 0          | that the de<br>led by the a<br>detached   | Physician/N      | 1 Yes 2 No<br>9 Unknown   | 9□ Unknown   |                    |                  |  |                            |                               |                                |                                    |                          |   |            |
| σ,         | s that<br>med t   |                  | Part II. Other significant conditions of  | ontributing to death bu  | ut not resulting i | n the ur         | derlying cause   | given in Pa                | urt I.                        | 23e. Did to                    | obacco use cont                    | ribute to th             | he cause of o                           | leath?     |
| ğ          | w requires<br>been signi<br>should be   | ed t             | Anoxic Encephalor   | pathy, Deme  | entia-             | Alzŀ             | neimer's   | Туре                       | 2                             | 101                            | Yes 2□No                           | 3 Prob                   | ably 4 <sub>X</sub> ⊡l                  | Jnknown    |
| Records,   | has be  | Completed by     |   |  |                    |                  |  |                            |                               | 24a. Was                       |                                    | Were auto                | psy findings<br>mpletion of c           | available  |
|            | The<br>cate h   | Соп              |   |  |                    |                  |  |                            |                               | perfo                          | rmed?                              | death?<br>I □ Yes        |   |            |
| /ita       | ician: Th<br>certificate<br>rector, pag   | Be               | 25. Was case referred to medical examiner?  | Hospital   |                    |                  | 1,   |                            |                               | (Check only o                  |                                    |                          |   |            |
| of Vital   | Physic<br>this c  | _T               | 1 ☐ Yes 2 🔀 No<br>27. Manner of Death   | Hospital: 1 ☐ Inpatie  |                    | tpatien          | t 3 DOA  |                            |                               |                                | dence 6 Oth                        |                          | <b>(y</b> )                             |            |
| Ö          | ding l<br>h.<br>After<br>funer  | tion             | 1 ⊠Natural 5 Pending 2 Accident investigation   | 28a. Date of Injur<br>(Month, Day                                    | Year)              | Injury           | 28c. In<br>V   | ork?<br>☐ Yes 2            |                               | .ou. Describe i                | now injury occur                   | <del>o</del> u           |   |            |
| Division   | Atten<br>r dea<br>ector.<br>by the  | ifica            | 3 Suicide 6 Could not b   | e 28e. Place of Inju   | ury - At home, fa  | arm, stre        |  |                            |                               |                                | Street and Numb                    | er or Rura               | al Route Num                            | ber,       |
| ā          | s afte<br>ai Dir  | Certification:   | 4   Horricide   | building, etc  | с. (Бреспу)        |                  |  |                            |                               | City or Tov                    | wn, State)                         |                          |   |            |
|            | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medical          | 29a. Certifier 12 Certifying Ph<br>(Check only one) 2 Medical Exam  | nysician: To the best of<br>miner: On the basis of<br>and manner sta | rexamination an    | e, death         | occurred at the<br>restigation, in m                   | time, date<br>y opinion, d | and place, a<br>death occurre | and due to the ed at the time, | cause(s) and ma<br>date and place, | nner as s<br>and due to  | tated.<br>the cause(s                   | ;)         |
|            | rothe<br>vithin:<br>o the<br>omple  | Mec              | 29b. Signature and title of certifier   | uniqualitier s(a   | T /                | <del>}</del>     | 29c. Lice  | nse numbe                  | ər                            |                                | 29d. Date signe                    | d (Month,                | Day, Year)                              |            |
| 1          | 041   |                  | 1 / Nousa   | 11.1 da  | mul/1              |                  | O Dr   | 05                         | 240                           | 1                              | Tune                               | 19 :                     | 2000                                    | 7          |
| 1          |   |                  | 30. Name and address of person who  | completed cause of d   | eath (Item 23a)    | (Type,           | Print)   | N                          | 101                           |                                | MILE                               | 1                        | - OV                                    | ,          |
| -          |   |                  | Thomas M. Hynu  | Lis, M.D.  | 10801              | Loc              | Kwood  | Pri                        | ve is                         | ilver.                         | Tune á<br>Spring                   | ,MD                      | 209                                     | 0/         |
|            | Sta<br>Registi  |                  | 31. Date filed (Month, Day, Year)   | 1006 32. Fegis ra  | ar's Signature     | 60               | and i  |                            | ,                             |                                | 1 )                                | L                        |   | 1          |

|                     |  | ľ              | 1 - For<br>Stete<br>Registrar   | State of Marylar  | -                                 |  | of Health and<br>of Death                  | _   | giene<br>Peg. No.                               | 22618  |
|---------------------|--|----------------|---|---|-----------------------------------|--|--|---|---|--|
|                     | <b>.</b>   |                | 1. Decedent's Name (First, Middle, Last)  |   |                                   |  |  | 2. Date of De                                     | ath<br>Day Year                                 | 3. Time of Death                                 |
|                     | Physici<br>/Medio  |                | Mary De Chantal   | Leen  |                                   |  |  | July  | 2, 2006   | 11:25 a M  |
|                     | Examir   |                | 4a. Facility Name (If not institution, give s   | street and number)  |                                   | 4b. City, Tow                                  | m, or Location of D                        | Death   | 4c. County of Dea                               | ath  |
|                     |  | *              | 512 Dennis Avenue   |   |                                   | Sil  | ver Sprin                                  |   |   | gomery   |
|                     | Funeral  |                | 5. Social Security Number 6. Sex 135-52-3291  | N MT  | last birthday)<br>49 Yrs.         | If Under 1 Y<br>Months Da                      |  | Min. (Month, Da                                   | y, Year) C                                      | rthplace (State or Foreign country)              |
|                     | Director   |                | Usual Residence of Decedent   |   | + 9                               |  |  | Aug. 21   | , 1956 New                                      | Jersey   |
|                     | yiand<br>now   |                | 10a. State 10b. County  | 10c. Ci   | ty, Town or Lo                    | ocation  |  |   |   | 10d. Inside City Limits                          |
|                     | Mar Mar  | ğ              | New Jersey Ocean  |   | Toms                              | River  |  |   |   | 1 ☐ Yes 2 X No                                   |
|                     | or 28  | Director       | 10e. Street and Number  |   |                                   | 10f. Zip Co                                    | de   |   | 10g. Citizen of What C                          | country?   |
|                     | 23s  |                | 39 Seward Avenue  |   |                                   | 0875   | 3  |   | USA   |  |
| 36                  | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or iteme 23s or 28s-1 show aumatic event, the Medical Exercitizat most be profilled at   | by Funeral     | 1 _XNever Married 2 ☐ Married   | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 2 ☐ No<br>If Yes, Give   |                                   |  | Cuban, Mexican, P                          | ? (Specify Yes or No<br>uerto Rican, etc.)        | Black, Whi                                      |  |
| Ş                   | hour<br>tural  | ed b           | 3 ☐ Widowed 4 ☐ Divorced  | Year or Dates:  | 16a Daca                          | dent's Usual O                                 | counation                                  | - 1   | 16b. Kind of Business                           | Madueto  |
| 5                   | in 72<br>in ra   | Completed      | (Specify only highest grade   | completed)  | (Give                             |  | one during most of                         | working   | 160. Kind of Business                           | sindustry  |
| 72                  | iene.  | E              | Elementary/Secondary (0-12)   | College (1-4or 5+)<br>5 +   | Speci                             | al Educ  | ation Te                                   | acher   | Educati   | on   |
| ਰੂ                  | illed<br>Hygir<br>other  | Bec            | 17. Father's Name (First, Middle, Last)   |   |                                   | -  |  | Name (First, Middle,                              | Maiden Surname)                                 |  |
| <u> </u>            | Aental<br>Aental<br>rked c   | To B           | James F. Leen   |   |                                   |  | М  | ary L. Bar  | rett  |  |
| Maryland 21215-0036 | nd 2 should tall hand Ment 27 le market raumatic e   |                | 19a. Informant's Name/Relationship (Typ<br>James F. Leen, III   |   |                                   |  |  |   | er, City or Town, State,<br>Beach, FL 3         | ,,   |
| Baltimore,          | permit. Pages 1 and 2 should be Department of Health and Menta Importants. If tiem 27 Ie marked eny Injury or other traumatic engree.  |                | 20a. Method of Disposition 1 5 Burial 2 ☐ Cremation 3 ☐ AR 4 ☐ Donation 5 ☐ Other (Specify)   | emoval from State   | cemetery, crei                    | osition (Name of<br>matory or other<br>ph's Ce | metery J                                   | Date uly 6,                                       | 20c. Location - City of                         |  |
| 3altir              | ermit. F<br>Separtme<br>nportar<br>ny Injur  |                | 21. Signature of Funeral Service License  |   | _                                 |  |  | 2006<br>ns Funeral                                | Toms River<br>Home Inc.                         | , New Jersey                                     |
| 8760,               | Physician and buysician and physician and physician and physician and the physician sit is a physician and physici | dical Examiner | shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any learner to immediate cause. Enter Undertying Cause (Disease or injury that intiated events resulting in death) Last | Due to (or as a consec  | quence of):                       |  | _  |   |   | Interval Between Onset and Death  9 Months       |
| .O. Box 68          | ath certif   | Physician/Med  | 1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of of | al death 3[                       | Ectopic pregn                                  |  |   | 23d. Date of de<br>Month                        | plivery<br>Day Year                              |
| <u>α</u>            | res that the de<br>igned by the a<br>be detached   | þ              | Part II. Other significant conditions con   | tributing to death but not res  | sulting in the u                  | nderlying cause                                | given in Part I.                           |   | obacco use contribute to                        |  |
| 9                   | w requir<br>been si<br>should I  | eted           |   |   |                                   |  |  |   | ′es 2 □ No 3 □ P                                | robably 4X_Unknown                               |
| al Records,         |  | Completed      |   |   |                                   |  |  | 24a. Was autop<br>perfor<br>1 ☐ Yes               | sy prior to death?                              | utopsy findings available completion of cause of |
| Vita                | Physician: Th<br>r this certificate<br>ral director, pag   | Be             | 25. Was case referred to medical examiner?  | ospital:  |                                   |  | Other                                      | Death (Check only o                               |   |  |
| ō                   | Phys<br>this<br>rat di   | ٦.             | 1 ☐ Yes 2 🛣 No  27. Manner of Death   | i l linpatient 2∟   | ER/Outpatier<br>28b. Time o       |  | 4   1401211                                |   | dence 6 Other (Spe                              | ecity)   |
| Ö                   | ding<br>Afte<br>fune   | 텵              | 1 X Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Year)  | Injury                            |  | Injury at<br>Work?<br>1 □ Yes 2 □ No       | 20d. Describe                                     | iow injury occurred                             |  |
| Division of         | or A<br>after<br>Direction by  | Certification; | 2 Accident Investigation 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At h<br>building, etc. (Speci                            | ome, farm, str<br>fy)             |  |  | 28f. Location (S<br>City or Tow                   | Street and Number or R<br>n, State)             | ural Route Number,                               |
|                     | To the Hoepital within 24 hours a To the Funeral completely filled   | Medical C      | 29a. Certifier 1⊠ Certifying Phys<br>(Check only one) 2 Medical Examin  | sician: To the best of my known or the basis of examinating and manner stated.  | owledge, death<br>ation and/or in | n occurred at the<br>vestigation, in r         | ne time, date and p<br>my opinion, death o | lace, and due to the o<br>occurred at the time, o | cause(s) and manner a<br>date and place, and du | s stated.<br>e to the cause(s)                   |
|                     | To the within 2 To the comple  | Me             | 29b. Signature and title of certifier   | A   |                                   | 29c. Lic                                       | cense number                               |   | 29d. Date signed (Mont                          | th, Day, Year)                                   |
|                     | V  |                | Mont fu   | und au  | >                                 | -  | D06959                                     |   | July 3,   | 2006   |
| 1                   | U  |                | 30. Name and address of person who co   | mpleted cause of death (Ite   | m 23a) (Type,                     | Print)   | בכבסטם                                     |   |   |  |
|                     | -  |                | Elba Martinez, M  | .D. 8808 Hid  | lden Hi                           | ll Lane  | , Potoma                                   | c, MD 2085  | 54  |  |
|                     | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)   | 32 Registrar's Sign   | ature Apr                         | all s  |  |   |   |  |

|                   |  |                      | 1 - For<br>State<br>Registrar  | State of I  | Maryland / D   | epartme<br><i>Certifica</i>  | nt of Healt<br>te of Dea                     | h and M<br>th           | Re   | g. No.                  | 96                              | 221                                   | 619                   |
|-------------------|--|----------------------|--|---|--|--|--|-------------------------|--|-------------------------|---------------------------------|---------------------------------------|-----------------------|
|                   | Physici<br>/Medic  |                      | 1. Decedent's Name (First, Middle, Last  |   | Y LUCILLE  | LANTZ  |  |                         | 2. Date of Death<br>Month<br>July  |                         | 2006                            | 3. Time of 7:25                       |                       |
|                   | Examin   |                      | 4a. Facility Name (If not institution, give 7117 Blue Mountain   |   | er)  |  | , Town, or Locati<br>urmont                  | ion of Death            |  | 4c. County<br>Fred      | of Death<br>leric               | k                                     |                       |
|                   | Funeral<br>Director  |                      | 5. Social Security Number 216-22-8194 6. Se  | 7.<br>]M 2 <b>∑</b> F                                     | Age (In yrs. last birt)<br>78  | nday) If Und<br>Months   |  | der 24 Hrs.<br>Irs Min. | 8. Date of Birth (Month, Day,  | <sup>Y</sup> 1927       | 9. Birthp<br>Coun<br>Mary       | lace (State<br>Tand                   | or Foreign            |
|                   | the Maryland<br>286-f show   | rector               | Usual Residence of Decedent  10a. State 10b. County  Maryland Frederi  10e. Street and Number  | ck  | 10c. City, Town  | nont   | p Code                                       |                         | 10   | g. Citizen of W         |                                 |                                       | City Limits           |
| တ္                | after death with<br>or Items 23e or  | by Funeral Director  | 7117 Blue Mountai  11. Marital Status  1 Never Married Married   | n . Road  12. Was Decede Amed Force 1 Yes 29 If Yes, Give | s?   | 13. Was Dec  | 21788  edent of Hispanic ecify Cuban, Mex    | ican, Puerto F          | cify Yes or No-<br>Rican, etc.)  | 14. Race<br>Black       | k, White,                       |                                       |                       |
| 21215-0036        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-1 show any injury or other treumetic event, the Medical Examinar must be malified at once. | Completed by         | 3 Widowed 4 Divorced  15. Decedent's Edu. (Specify only highest grade  Elementary/Secondary (0-12)  11   | Year or Date  | 16a.   | Decedent's Us<br>(Give kind of w<br>life. DO NOT   | ual Occupation<br>ork done during r          |                         | ng 1   | Specify: 6b. Kind of Bu | usiness/Inc                     |                                       | actory                |
| Maryland          | uld be file<br>fental Hyg<br>rked othe<br>tic event,   | To Be C              | 17. Father's Name (First, Middle, Last) Harold Ernest Swe  | eney  |  |  |  | other's Name<br>.ldred  | (First, Middle, Ma<br>Davis  |                         |                                 |                                       |                       |
|                   | nd 2 shoulth and N<br>27 Is mai  |                      | 19a. Informant's Name/Relationship (T) Herman L. Lantz /   |   |  | -  |  |                         | Route Number, Thurmo   |                         |                                 |                                       |                       |
| Baltimore,        | ages 1 ar<br>ent of Hea<br>nt: If item<br>y or othe  |                      | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)   | lemoval from Sta  | 20b. Place of  | Disposition (N. crematory or   | me of<br>other place)                        | ,                       | ate 20   | Oc. Location - (        | City or To                      | own, State                            | 1                     |
| Baltir            | permit. F<br>Departme<br>Importen<br>any injur   |                      | 21. Signature of Funeral Servic Cicens   | 0   | prue Ki  | 22. Name :<br>ROBERT   | nd Address of Fa                             | EY & S                  | ON FUNER THURMO  | AL HOM                  | ES, E                           | P.A.                                  | 1                     |
| 68760,            | /Medical Examiner bhysician and the burial-transit   | al Examiner          | 23a. Part1. Enter the disease, or combishook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or  | n line.  | obtenter the modern of the mod | de of dying, such                            | as cardiac or           |  | st,                     |                                 | Approxima<br>Interval Be<br>Onset and | tween                 |
| P.O. Box 687      | The law requires that the death certificate ate has been signed by the attending physbage 2 should be detached for use as the  | Physiclan/Medical    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes  No 9 Unknown  |   | 1 2 ☐ Fetal death<br>t at time of death  | 3 ⊟Ectopic<br>5 ⊡ Other (  |  |                         |  | 23d. Date<br>Mon        | e of delive                     | *                                     | Year                  |
|                   | luires that<br>n signed by   | by                   | Part II. Other significant conditions con  | ntributing to deat  | h but not resulting in   | the underlying   | cause given in Pa                            | art I.                  | 23e. Did toba  | cco use contri          |                                 | ne cause of o                         |                       |
| Il Records,       |  | Completed            |  |   |  |  |  |                         | 24a. Was an autopsy performs   | 1Q                      | Vere autoprior to com<br>leath? | psy findings<br>npletion of c         | available<br>cause of |
| Division of Vital | or Attending Physicien: The lavafler death. Director: After this certificate has I in by the funeral director, page 2  | Certification; To Be | 25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined  | 28a. Date of li<br>(Month, i                              | atient 2 ER/Out<br>njury 28b. Ti<br>Day Year) In<br>Injury - At home, fari<br>etc. (Specify)   | me of<br>jury<br>M   | OA Other: 4 = 28c. Injury at Work? 1 = Yes 2 | Nursing Horn<br>2       | (Check only one)  ne siden  8d. Describe how  8f. Location (Stre City or Town, | injury occurre          | ed                              |                                       | mber,                 |
| ۵                 | To the Hospitel or Attenswithin 24 hours after dealt To the Funerel Director: completely filled in by the  | edical Cer           |  | sician: To the be   | est of my knowledge.   | death occurre  | at the time, date                            | and place, a            | nd due to the cau  | se(s) and man           | ner as sta                      | ated.                                 | e)                    |
| )                 | To the Hospitel within 24 hours To the Funerel completely filled   | Medi                 | 29b. Signature and title of certifier  | mno manner  | stated.  | 2:   | c. License numb                              | er                      | 290  | Date signed             | (Month, E                       | Day, Year)                            |                       |
|                   | 10   |                      | 30. Name and address of person who co  | empleted cause of   | of death (Item 23a) (The second secon | ype, Print)  | ENEST  | x st                    | FRE  | SERICA                  | K,                              | 4pZ                                   | 1781                  |
|                   | Sta<br>Registr   | -                    | 31. Date filed (Month, Day, Year)  | 32. Regi  | stress Signature   | y do   | AL.  |                         | /  |                         |                                 |                                       |                       |

State of Maryland / Department of Health and Mental Hygiene 22620 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Little Month **Physician** DORIS June 25 2006 1:18 A.M. /Medical 4c. County of Deeth Prince George's 4a Fecility Neme (ff not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Forestville Health and Rehabilitation Center Forestville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1 □ M 2 🖫 F 64 578-31-5166 Director December 22,1941 Washington, D.C. Usuet Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Suitland Prince George's Maryland 1 DXYes 2 □ No Funeral Director 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 20746 U.S.A. 4248 Suitland Road Apt. #202 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Husekeeping Domestic Engineer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ella Thompson Charles E. Thompson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. James A. Little, Jr. (Son) 3001 Branch Avenue Apt. #626 Temple Hills, Maryland 20748 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State July 3, 2006 Suitland, Maryland Lincoln Memorial Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rollins Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4339 Hunt Pl. N.E. Washington, D.C. 20019 willest Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CHRONIC OBSTRUCTIVE Pulmimary disease Examiner Due to (or as a consequence of): Examiner Aryngial Cancer
Due to (of as e consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician end for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, Lung cancer by Physician/Medical Due (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 X Yes 2 No 3 Probably 4 Unknown HYDertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 22 No 1 ☐ Yes 2 ☐XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 M Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 X No eral Director: After this filled in by the funeral di 27. Menner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier D 51520 06-28-2006 30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 20032 WASHINGTON DC SOUTHERN Ave. 5E 310 1328 31. Dete filed (Month, Day, Year) Registrer's Signature State Registrar 0 3 2006

**DHMH 16 Rev 6/95** 

|                                |   |                  | 1 - State Registrar  | Department of Health and N<br>Certificate of Death  |   | ene 006 22621  |
|--------------------------------|---|------------------|--|---|---|--|
|                                | Physici   |                  | 1. Decedent's Name (First, Middle, Last)  Arthur Edwin Levy, Ji  | r   | 2. Date of Death<br>Month<br>July 1       | Day Year 11:05 A M   |
| B                              | /Medio<br>Examin  |                  | 4a. Facility Name (If not institution, give street and number) 42083 Woodland Road   | 4b. City, Town, or Location of Death Mechanicsvill  | е   | 4c. County of Death St. Mary's   |
| ٠                              | Funeral<br>Director   |                  | Usual Residence of Decedent  | Yrs. Months Days Hours Min.   | 8. Date of Birth (Month, Day, Y July 6, 1 |  |
|                                | n the Maryla<br>r 28e-f shov  | Director         |  | anicsville  10f. Zip Code   | 100                                       | 10d. Inside City Limits 1 ☐ Yes 2 1 No g. Citizen of What Country?   |
| 36                             | be filed within 72 hours after death with the Maryland tal tyglene.  al dyglene death all, or items 23a or 28e-f show do other than "natural", or items 23a or 28e-f show event, the Medical Examinar must be notified at | by Funeral D     | 42083 Woodland Road  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  Road  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Narried If Yes, Give Year or Dates:   | 20659  13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto                         | pecify Yes or No-<br>Rican, etc.)         | USA  14. Race - American Indian, Black, White, etc.  Specify: White  |
| Baltimore, Maryland 21215-0036 | within 72 hour<br>iene.<br>r then *natural'<br>tre Medical Ex   | Completed b      | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)   | Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) elivery Man | ring 16                                   | Sb. Kind of Business/Industry  Grocery   |
| ryland 2                       | be d la   | To Be C          | 17. Father's Name (First, Middle, Last) Arthur Edwin Levy, Sr.   | 18. Mother's Nam  |   | Thompson   |
| ore, Mai                       | of Health of Hem 27 is  |                  | Lillian Mae Levy / Wife 42   | 083 Woodland Road, Mechan   | icsville, M                               |  |
| Baltimo                        | permit. Pages<br>Department of<br>Important: If it<br>any injury or o   |                  |  | Memorial Gardens July 1  22. Name and Address of Facility Mattingley Gardiner Fun P.O. Box 270, Leonardto     |   |  |
| 8760,                          | Cate be executed hysician and physician and physician and the burial-transit  | dicai Examiner   | 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or conditions resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the con | not enter the mode of dying, such as cardiac lewal effusiven whose of yight lung                              |   |  |
| O. Box 68                      | that the death certificated by the ettending podetached for use as to   | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown  | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)   |   | 23d. Date of delivery<br>Month Day Year  |
| cords, P.                      | v requires<br>been sign<br>should be  | Completed by Ph  | Part II. Other significant conditions contributing to death but not resulting in   | n the underlying cause given in Part I.   | 1 ☐ Yes<br>24a. Was an                    | cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were aulopsy findings available |
| Vital Re                       |   | To Be Com        | 25. Was case referred to medical examiner?  1   Yes   2   No   | Othor   | th (Check only one)                       | prior to completion of cause of death?  I ∩ Yes 2 No  Cee 6 □Other (Specify)                               |
| Division of Vital Record       | Attending r death.  | Certification: T | 27. Manner of Death 28a. Date of Injury 28b.   | Time of njury at Work?  M 1 Yes 2 No  | 28d. Describe how                         | et and Number or Rural Route Number,   |
| _                              | Hospital 4 hours Funerel ely filled   | edicai Ce        | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated.  | a, death occurred at the time, date and place,<br>d/or investigation, in my opinion, death occur              | and due to the cau                        | se(s) and manner as stated. e and place, and due to the cause(s)   |
|                                | To the within 2 To the i complete   | W                | 29b. Signature and title of certifier  | 29c. License number  D 00 51 7  | 38 6                                      | 1. Date signed (Month, Day, Year)  |
| 15                             | sta   | ite              | 30. Name and address of person who completed cause of death (Item 23a)  KAE T, AUNG 244 35  31. Date filed (Month, Day, Year) 1 2006  32.1 Sgistrar's Signature  | (Type, Print) MERVELL DEAN  | 1. RD. H                                  | OLLYWOOD MD  |
|                                | Regist  | ar               | JUL TI COOD AND SEE  | Agent   |   |  |

State of Maryland / Department of Health and Mental Hygiene 🔎 🗍 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 07 Day **Physician** 3:20 P M Herman Virgil Larimore 05 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Home for Hospice Denton Caroline If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 79 Yrs 222-16-0424 2/15/1927 Delaware **Director** Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County is 1 and 2 should be filed within 72 hours after death with the Marylan of Heelth and Mental Hygiene. Item 27 is marked other than "naturel", or itema 23a or 28a-1 show other treumatic event, it a Medical Exacting must be inclifted at 1 ☐ Yes 2 X No Director Caroline Greensboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12584 Knife Box Road 21639 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status e filed within 72 hours after all Hygiene.
other than "naturel", or Ital 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 9 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation re kind of work done during most of working DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Compounder Playtex Industries 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Larimore Lucy Tharp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Diane Pippin / daughter 25880 Dogwood Road; Greensboro, MD 21639 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Importent: If iter
any injury or oth 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Greensboro Cemetery 7/8/2006 Greensboro, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetel death in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 this certificate 1□ Yes 2 No To the Hospitei or Attanding Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 146 မ 3□ DOA After the 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident filled in by the Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) WID 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easton MD 21601 Whitesel MD 505A 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

the Maryland With deeth Baltimore, Maryland 21215-0036

Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** July 2, 2006 Julius 7:00A Luria /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 2, 1918 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1**7** M 2□ F Yrs. W۷ 212-14-7703 88 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ₩OH@ rthan "naturel", or iteme 23s or 28s-f ehor the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** MD Montgomery Silver Spring 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 10119 Greeley Avenue 20902 USA Was Decedent Ever in U.S. Armed Forces? 1 Aves 2 No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "nature!; or item any injury or other treumatic event, the Mudical Examples and page. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify. Be Completed by 3 NWidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Button Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Luria Fannie Miller ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Campbell - daughter 10119 Greeley Avenue Silver Spring MD 20902 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial 7/3/06 Falls Church VA Gardens
22. Name and Address of Eacility
Danzansky-Goldberg Memorial Chapels Inc. 21. Signature of Funeral Service Dicenses 1170 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner ettending physicien and for use as the burial-transit Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 A Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 Yes 2 XNo 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 
☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 XNo 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours e 29s Cartifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number 5434 07-02-2006 suse of death (Item 23a) (Type, Print) Neeraj Chapra PO Box 83819 Gaithersburg MD 20883 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 JUL 05 Registrar BARRE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** JUN 27 12:20 PM 2006 W.H.I.MOOS /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct 14 1943 Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F Yrs 116-34-9938 Director Usuat Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or itsms 23a or 28a-f show other traumatic sysnt, the Madical Examinar must be notified at Calvert Maryland St. Leonard 1 TYes 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1598 Laurel Road 20685 Unitd States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene Important; if item 27 is marked other than "naturst; or Item any injury or other traumatic syent; the Madical Examina Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 66-91 þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Cotlege (1-4or 5+) 5+ Elementary/Secondary (0-12) Marine Corp Colonel US Military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony Moos Dorothy Irvine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 22 St. Leonard MD 20685 <u> Linda Vlier Moos - wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place June 29 Pate 2006 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Funeral Service Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) 21 gnature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home20676 4405 Broomes Island Rd. Port Republic 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NON SMALL CELL LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 2 No 1 Yes 1 Yes Hospital or Attending Physician: ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) s after death.
I Director: After this cend in by the funeral direc Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Xatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of tniury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 24 ho
To the Functional To the 29b. Signature and time of certain 29d. Date signed (Month, Day, Year) 29c. License number 0 06-27-06 0102201779 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER

10+1

State Registrar

ANDREW J. PETERSON CAPT MC USAF 31. Date fited (Month, Day, Year) 32. Registres s Signature 2006

BETHESDA MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** RONALD JUNE 2006 MATTHEW MORSELL 26, 8:35 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7113 Dewdrop Way Clinton Prince George's 8. Date of Birth (Month, Day, Year) Dec 5, 1950 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min 1<del>2</del> M 2□ F 55 215-56-8235 Yrs Director Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Itams 23s or 28e-f ahow the Medical Example must be codified at Prince George's Clinton 1 Yes 2 XVo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7113 Dewdrop Way 20735 U.S.A. Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 72 hours after 1 Never Married 2 Married If Yes, Give Year or Dates: VIETNAM ERA ☐ Yes 2XNo Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. **Heavy Duty Operator** Construction avant. 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Heelth and Mental Joseph Morsell Dorothy Washington traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerwin Morsell/son permit. Pages 1 and 2 Department of Heelth a Important: If item 27 is any injury or other trai 1436 Fowler Road Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 07/05/06 Cheltenham Veterans' Cemetery Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Sewell Funeral Home Glady sewel 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIOVASCULAR COLLAPSE /Medical Due to (or as a consequence of) Examiner CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed VALVULAR DISEASE and burial-tran Due to (or as a consequence of): the attending physician Be Completed by Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ed bluods 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 245 No 1 Yes Physician: director. 25. Was case referred to medical examiner? 26 Place of Death (Check only one Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2X No 1 🗌 Inpatient Certification: To 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attanding 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide Hospitel tilled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check of one) completely and manner stated within 2 To the the 29b. Signature title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0

State Registrar JACQUELINE A.

31. Date filed (Month, Day, Ye

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pay, Year) 2006

Registrar's Signature

MD# 31890

CORRIGAN-CURAY, M.D. VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422

JUNE 30, 2006

|                |  |                  | For  | State                                   | e of Maryla   | •                       | artment of I                           |                    |               |                                | - /           | 106                              | 226  | 26        |
|----------------|--|------------------|--|---|---|-------------------------|--|--------------------|---------------|--------------------------------|---------------|----------------------------------|--|-----------|
|                |  |                  | <ul> <li>State<br/>Registrar</li> <li>Decedent's Name (First, Middentification)</li> </ul> | tla Last\                               |   |                         | uncale of                              | Dealii             |               | 2. Date of Dea                 | th            | J (J (J )                        | 3. Time of E                                 | Same 1997 |
|                | Physicia   | an               |  |   |   |                         |  |                    |               | Month                          | Day           | Year                             |  |           |
|                | /Medic   |                  | Martha Lucres  4a. Facility Name (If not instituti   |   |   |                         | 4b. City, Town,                        | or Location o      | of Death      | July                           | 4c. Cou       | 2006<br>nty of Death             | 0.13   | Р         |
|                | Examin   | er               |  |   |   |                         |  |                    |               |                                |               |                                  | _  | i         |
|                | Funeral  |                  | Williamsport 5. Social Security Number   | 6. Sex                                  |   | . last birthday)        | If Under 1 Year                        |                    | 24 Hrs.       | 8. Date of Birth               | 1             | ingtor<br>9. Birthp              | lace (State or<br>htry)                      | Foreign   |
|                | Director   |                  | 219-12-2301  | 1□ M 2 <b>X</b>                         | F 92  | Yrs.                    | Months Days                            | Hours              | Min.          | (Month, Day<br>1ay 30          |               |                                  | ryland                                       |           |
|                | and **   |                  | Usual Residence of Decedent  10a. State 10b. Count   | у                                       | 10c. C  | ity, Town or Lo         | ecation                                |                    |               |                                |               | 1                                | 0d. Inside City                              | / Limits  |
|                | Maryl<br>f eho   | ō                | M1 171   |   |   | II                      | <del>-</del>                           |                    |               |                                |               |                                  | 1 <b>X</b> □Yes                              | 2 🗌 No    |
|                | 28a  | Director         | Maryland Wash 10e. Street and Number   | iington                                 |   | над                     | 10f. Zip Code                          |                    |               |                                | 10g. Citizen  | of What Cour                     | itry?  |           |
|                | 3a or  |                  | 1379 Marshall  | Stroot                                  |   |                         | 21.                                    | 740                |               |                                | USA           |                                  |  |           |
|                | death  | Funeral          | 11. Marital Status   | 12. Was                                 | Decedent Ever in  | U.S. 13.                | Was Decedent of<br>If Yes, specify Cub |                    | igin? (Spec   | rfy Yes or No-                 |               | lace - Americ                    |  |           |
| ٥              | or ite   | Ē                | 1 Never Married 2 Ma   | rried 1 🗆 Y                             | d Forces?<br>′es 2 ∑ No<br>s,Give   |                         | 1 □ Yes 217 No                         |                    |               | iican, etc./                   | Spe           | llack, White,                    | etc.   | İ         |
| 5              | hours after death with the Maryland<br>tural; or iteme 23a or 28a-f ehow<br>al Exament intel or notified at  | d by             | 3 ₩ Widowed 4 Divorce  | d Year                                  | or Dates:   |                         | - ZANO                                 | эроспу.            |               |                                |               | Whi                              |  |           |
| 21215-0036     | 72 h<br>'natu  | Completed        | 15. Decede<br>(Specify only high   | nt's Education<br>est grade comple      | ted)  | (Give                   | dent's Usual Occu<br>kind of work done | during mos         | st of working | g                              | 16b. Kind of  | Business/Ind                     | dustry                                       |           |
| 2              | han na   | D E              | Elementary/Secondary (0-12)  | Colle                                   | ge (1-4or 5+)   |                         | DO NOT use retire                      |                    |               |                                |               | _                                |  |           |
| 7              | Hygie<br>Ther I  |                  | 17. Father's Name (First, Middle   | . Last)                                 | 0   | Fa                      | ctory wo                               |                    | er's Name     | (First, Middle,                |               | n Fact                           | tory   |           |
| ano            | od be  | ) Be             | Adolph C. Hot  |   |   |                         |  |                    |               | Robins                         |               | ŕ                                |  |           |
| Maryland       | should be and Mental I smarked o   | ဦ                | 19a. Informant's Name/Relation   |   | )   | 19b. Maili              | ng Address (Stree                      | <del></del>        |               |                                |               | vn, State, Zip                   | Code)  |           |
| Ž              | s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. If the 21 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Modical Examinations in notified at |                  | Richard L. Ma  | nspeaker                                | r - Son   | 1379                    | Marshal:                               | 1 Stre             | et. F         | lagerst                        | own. №        | d. 217                           | 740  |           |
| altimore,      | es 1 e<br>of Hes<br>fitem<br>rothe   |                  | 20a. Method of Disposition   |   | 20b.  | Place of Dispo          | sition (Name of<br>matory or other pla |                    |               | ate                            |               | n - City or To                   |  |           |
| E              | Pages<br>nent of<br>int: if it<br>iry or o   |                  | 1 🕅 Burial 2 🗍 Cremation<br>4 ☐ Donation 5 🗍 Other   |   |   |                         | n Memoria                              | 1                  | rk 7/8        | 3/06                           | Willia        | msport                           | . Marv                                       | 1and      |
| a              | permit. Pages<br>Department of<br>Important: if it<br>eny injury or o  |                  | 21. Signature of Euneral Service   | e Licensee                              | 27 -  |                         | 2. Name and Addr                       |                    |               |                                |               |                                  | - N  |           |
| <u> </u>       | 8258   |                  | 2000   | 1 11/1                                  | Junne   | 4                       | 15 E. Wi                               | lson B             | Blvd.         | Hagers                         | town,         | Mary1a                           | and 217                                      | 40        |
|                |  |                  | 23a. Part1. Enter the disease, shock, or heert failure. Li                                 | or complications t<br>st only one cause | hat caused the de-<br>on each line.   | ath. Do not en          | ter the mode of dy                     | ing, such as       | s cardiac or  | respiratory ar                 | rest,         |                                  | Approximate<br>Interval Betw<br>Onset and Do | een       |
|                | Physician  |                  | Immediate Cause (Final disease or condition  | , c                                     | erebroi   | 1ascul                  | ar ac                                  | cider              | nt            |                                |               |                                  | 2 day  | 5         |
|                | /Medical<br>Examiner   |                  | resulting in death)  | Du                                      | e to (or as a conse   | equence or):            |  |                    |               |                                |               |                                  |  |           |
|                | LAGITITIES   | _                | Sequentially list conditions,  | bd                                      | 10 bete.  | s me                    | 211, tus                               |                    |               |                                |               |                                  | years  | ·         |
|                | ed<br>isit   | ulne             | if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury              | ₹                                       | /   | <b>,</b>                |  |                    |               |                                |               | ,                                | vears  |           |
|                | s be executed<br>sicien and<br>burial-transit  | Examiner         | that initiated events<br>resulting in death) Last  |   | PETTER  |                         |  |                    |               |                                |               | -                                |  |           |
| 760            | te be executed<br>ysicien and<br>ie burial-transit   | calE             |  | Ld                                      |   |                         |  |                    |               |                                |               |                                  |  |           |
| 89             |  |                  |  |   |   |                         |  |                    |               |                                | 1             |                                  |  |           |
| ŏ              | th cert<br>endin<br>r use  | 10€              | IF FEMALE:<br>23b. Was decedent pregnant   |   | outcome of preginter and of preginter a |                         | ⊒Ectopic pregnanc                      | CV                 |               |                                |               | Date of delive                   | *  |           |
| P.O. Box       | Attending Physicien: The law requires that the death certificate be excleath. cloath. ector: After this certificate has been signed by the attending physicien by the funeral director, page 2 should be detached for use as the buria   | by Physician/Med | in the past 12 months?<br>1 ☐ Yes 2 ☑ Ño<br>9 ☐ Unknown                                    | 4□F                                     | Pregnant at tim <i>e</i> of<br>Unknown  |                         | Other (specify)                        |                    |               |                                |               | Month                            | Day Ye                                       | ear       |
| <u>ď</u>       | hat th<br>od by<br>detacl  | 듄                | Part II. Other significant condi   | tions contributing                      | to death but not re   | asulting in the u       | inderlying cause o                     | iven in Part I     | ł.            | 23e. Did to                    | bacco use c   | ontribute to th                  | ne cause of de                               | eath?     |
| Vital Records, | uires t<br>signe   | d by             | dementia   |   |   | , -                     | 1                                      |                    |               | 1 🗆 Y                          | es 2 DN       | 3 Prob                           | oably 4 ∐Ur                                  | nknown    |
| Ö              | w req  | ete              |  |   |   |                         |  |                    |               | 24a. Was                       | an 24         | b. Were auto                     | psy lindings a                               | vailable  |
| Re             | ding Physicien: The lav<br>h.<br>After this certificate has<br>funeral director, page 2  | Completed        |  |   |   |                         |  |                    |               |                                | med?          | prior to co<br>death?<br>1 ☐ Yes | mpletion of ca                               | use of    |
| ta             | en: Tifical<br>tor, p  | 0                | 25. Was case referred to medic   | al                                      |   |                         |  | 26. Place          | e of Death    | Check only o                   | _             | 1 163                            | 21110  |           |
| >              | nysici<br>nis ce<br>direc  | To B             | examiner?<br>1 ☐ Yes 2 █ No  | Hospital:                               | 1 ☐ Inpatient 2 [   | ☐ ER/Outpatie           | nt 3□ DOA                              | ther: 4 M          | ursing Hom    | ne 5 ⊟ Resid                   | lence 6 □0    | Other (Specif                    | y)   |           |
| 0              | fler thunderal   |                  | 27. Manner of Death 1 Natural 5 □ Pend   | 28a. I                                  | Date of Injury<br>(Month, Day Year)   | 28b. Time o             | of 28c. Inju                           | ury at<br>ork?     | 2             | 8d. Describe h                 |               |                                  |  |           |
| Sio            | tendi<br>leath.<br>Ior: A<br>the fu  | catl             |  | stigation                               |   |                         |  | ∃Yes 2□            |               |                                |               |                                  |  |           |
| Division of    | To the Hospital or Attend within 24 hours efter death To the Funeral Director: completely filled in by the   | Certification:   |  | mined 280.                              | Place of Injury - At<br>building, etc. (Spec  | home, larm, st<br>cify) | reet, factory, office                  | •                  | 2             | 81. Location (S<br>City or Tox |               | m <i>oer</i> or Hura             | II HOUIØ NUMB                                | ier,      |
|                | pital<br>ours cours<br>beral<br>filled   |                  | 29a. Certifier 1 Certifi   | ring Physician: T                       | o the best of my k  | nowledge deal           | th occurred at the                     | time date ar       | nd place, a   | nd due to the                  | cause(s) and  | manner as s                      | tated.                                       |           |
|                | • Hos  | Medical          | (Check only 2 Medic  | al Examiner: On                         | the basis of exami<br>manner stated.  | nation and/or in        | nvestigation, in my                    | opinion, dea       | ath occurre   | d at the time,                 | date and plac | e, and due to                    | the cause(s)                                 |           |
|                | To th<br>within<br>To th<br>comp   | ¥.               | 29b. Signature and title of certi  | fier                                    |   | 0                       |  | ns <i>e</i> number |               |                                |               | ned (Month,                      |  |           |
|                |  |                  | Cynthia  | Kw                                      | ner . S   | ands,                   | D                                      | 474                | 51            | -                              | Tuly          | 6,20                             | 006  |           |
|                | :/ >   |                  | 30. Name and address of person   | on who completed                        | cause of death (It  | em 23a) (Type           | Print)                                 | Nurs               | 109 H         | lome.                          | 154 N         | orth,                            | Artizo                                       | 2.17      |
| Y              | 6-3  |                  | Cynthia Kutt   | ver. 201                                | DA 2D   | 70, //, d               | S                                      | Freet              | E, W          | Mans                           | port,         | Mary                             | land 21                                      | 795       |
|                | Sta<br>Regist  | ate<br>rar       | 30. Name and address of person<br>Cynthia Kutt<br>31. Date filed (Month, Day, Ye           | 7 2006                                  | 32. Hagistrar's Sig   | H. L                    | perke                                  |                    |               |                                | -             | •                                |  |           |
|                |  |                  | <del></del>  |   | 1   |                         |  |                    |               |                                |               |                                  |  |           |

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** 4:48 PM 30. 2006 June Maxine Minnie Mulvey /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's College Park 5807 Swarthmore Drive | Il Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Min. | March 30, 1924 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Virginia Months Days 82 Yrs. 579-20-9269 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County **ehow** r than "natural", or items 23a or 28e-f ehor the Modical Examinar must be notified at 1 Tyes 2 No Directo Marvland Prince George's College Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20740 USA 5807 Swarthmore Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Copartment of Heelih and Mental Hygiene. Important: if itam 27 is marked other than "natural, or ite any injury or other traumatic event, the Musical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 → Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Business 10 Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Mae Orndorff Harry Luther Cameron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 East Indian St., Fenwick Island, DE Elsie A. Weistling, Daughter Date 2006 by 2, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriai 2 XCremation 3 ☐ Removal from State Metropolitan Crematory July Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, P.A. 21. Signature of Funeral S wie Lice see 20705 4400 Powder Mill Rd., Beltsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure **Physician** /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine anding physicien and use as the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12-months? 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown څ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2X No 2 No After this certificate funeral director, pag 1 Yes 1 ☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death el or Attending P s after death. 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel c within 24 hours af To the Funeral D completely filled in 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier D58603 July 2, 2006 10 30. Name and address of person what peopleted cause of death (Item 23a) (Type, Print) 3720 Upton Street, N.W. Matt Kestenbaum, M.D. Washington, DC 31. Date filed (Month, Day, Year) egistrar's Signature JUL 03 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** BROOK MOORE JULY 1 2006 9:08 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner MONTGOMERY SANDY SPRING 16700 NORWOOD ROAD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, SEPT . 12 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7 Age (In vrs. last birthday **Funeral** Days Hours Min 1**⊠** M 2□ F 90 MARYLAND 218-01-7455 1915 Director Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10d Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 1 Yes 2 No SANDY SPRING MONTGOMERY MD. Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe 20860 16700 NORWOOD ROAD UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentai Hygiene. Inhorteant if it fiem 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CUSTOM FURNITURE WOOD WORKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WETHEARLD HET.EN WILLIAM MOORE W. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20860 16700 NORWOOD ROAD, SANDY SPRING, MD. J. LEWIS MOORE / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 7/2/06 ALEXANDRIA, VA. METROPOLITAN CREM. \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
MURIEL H. BARBER FUNERAL HOME 21. Signature of Funeral Service Licenses N. Barber muriel BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disease, or complications that caused the death. Oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PROSTATE CANCER Immediate Cause (Final Physician Two Years resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner requires that the death certificate be axecutad burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physiclan/Medlcal as the IF FEMALE esn nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year į in the past 12 months? Month 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ RENAL STONES WITH HYDRONEPHROSIS 3 Probably 4 Unknown 1 ☐ Yes 2 No should Completed baen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has page 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home To Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 X Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. escribe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident Injury 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only 29b Signature and title of certifier 29c. License number 123174 MISTA 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DENVIS HANNON MO'XID OLNEY SANDY SPRING RD, OLNEY MARYLAND

31. Date filed (Month, Day, Year)

32. Registrar's Signature State 2006 JUL 03 Registrar

|  |  | Tor<br>State<br>Registrar   |   | Co  | ertificate   | of Death   |   | giene 006  | 22630   |
|--|--|---|---|---|--|--|---|--|---|
| Physicia<br>/Medic   |  | Decedent's Name (First, Middle, I     Mary Menard   |   |   |  |  | 2. Date of Dea<br>Month<br>July 2,  | Day Year<br>2006   | 3. Time of Death 7:20 a. M  |
| Examin<br>Funeral<br>Director  | er<br>   | 4a. Facility Name (If not institution, g 5188 Almeria 5. Social Security Number 024-30-3765   | Court   | e (In yrs. last birthda<br>67 Yrs.  | Mt.  | wn, or Location of De Airy  fear If Under 24 H lays Hours M  | Irs. 8. Date of Birth   | 4c. County of Death Frederi (Year) 9. Birth Cou 31. 1939Mas  |   |
|  | ctor   | Usual Residence of Decedent  10a. State 10b. County  Maryland Frederi   | ck  | 10c. City, Town or Mt. Airy   | Location   |  | <i>quindzy</i>  |  | 10d. Inside City Limits   |
| 23a or 28  | ai Director  | 10e. Street and Number<br>5188 Almeria Cou  | rt  |   | 10f. Zip Co<br>21  | 771  |   | U.S.A.   | intry?  |
| lai rygiene.<br>d other then "naturel", or itame 23a or 28e-1 ehow<br>event, The Madical Examiner must be multiked at                            | by Funerai   | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced   | 12. Was Decedent Armed Forces?  1   | Ever in U.S. 13   | 3. Was Deceden<br>If Yes, specify<br>1 ☐ Yes 2√x   | t of Hispanic Origin?<br>Cuban, Mexican, Pu<br>No <i>Specify:</i>  | (Specify Yes or No-<br>erto Rican, etc.)  | 14. Race - Ameri<br>Black, White,<br>Specify: W  |   |
| iene.<br>r then "natur<br>the Maulcal  | Completed  | 15. Decedent's (Specify only highest of Elementary/Secondary (0-12)   | Education grade completed)  College (1-4or 5  | )+)   |  | Occupation done during most of v retired)  Reception   |   | 16b. Kind of Business/Ir  Education  | ndustry   |
|  | To Be C  | 17. Father's Name (First, Middle, La<br>Malachi Kittre  | edge  |   |  | Mae A  | lame (First, Middle,<br>Andrews   |  |   |
| t or rieelin and Mer<br>If Itam 27 ie marke<br>or other traumatic  |  | 19a. Informant's Name/Relationship Susan Menard - I  20a. Method of Disposition   |   |   | Freenvie   | w Drive,   | Rochester   | r, City or Town, State, Zi<br>New York   | 14620   |
| Department Important: any injury once  |  | 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe 21. Signate spot Funeral Service) 23a. Part 1. Enter the disease, or coshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  | city)  ensee  Mulle  mplications that cau and you one cause on each line  | Frederic<br>Ithe death. Do not ene.   | 22. Name and A   | Address of Facility SEUM LOWN  | tauffer Fi  |  |   |
| Medical<br>caminer   | ner  | 165diding in death)   | Due to (or as   | a consequence of):  |  |  |   |  | -,  |
| ysicien and<br>ne burial-transit   | icai Examiner  | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | c. Due to (or as  | a conseque  | C  | 30610  | -   | uns (7   | 2043  |
| or use as the  | icai   | that initiated events   | c. Due to (or as d. 23c. If yes, outcome  | a consequence of):  of pregnancy 2 ☐ Fetal death  | B Ectopic preg   | nancy  |   | 23d. Date of delive Month  | Yery<br>Day Year  |
| gned by the ettending phy:<br>oe detached for use as the   | by Physician/Medicai                                       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No   | Due to (or as  Due to (or as  d.  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown   | a consequence of):  of pregnancy 2 Fetal death time of death  | B Ectopic preg   | nancy<br>fy)   | 23e. Did to   | 23d. Date of deliv   | Day Year the cause of death?  |
| is been signed by the ettending phy:<br>2 should be detached for use as the  | e Completed by Physician/Medical                           | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as  Due to (or as  d.  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown   | a consequence of):  of pregnancy 2 Fetal death time of death  | B Ectopic preg   | nancy<br>fy)se given in Part I.  | 23e. Did to  24a. Was a autop: perfor 1 □ Yes   | 23d. Date of delive Month  bacco use contribute to the Second 24b. Were autory prior to contribute and?  | Day Year the cause of death? bably 4 Unknow opsy findings availab ompletion of cause o  |
| as been signed by the ettending phy:<br>2 should be detached for use as the  | To Be Completed by Physician/Medical                       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as  Due to (or as  Due to (or as  Due to (or as  Due to (or as  Due to (or as  | a consequence of):  of pregnancy 2 Fetal death time of death ut not resulting in the  | B Ectopic preg   | nancy se given in Part I.  26. Place of D Other: 4 \( \text{Nursing} \)  | 23e. Did to  24a. Was a autoping perfor 1   Yes Death Check only or g Home 5 Resid  | 23d. Date of delive Month  bacco use contribute to the Second Sec | Day Year the cause of death? bably 4 □Unknow opsy findings availab ompletion of cause o 2 □ No  |
| death.<br>ctor: Afler this certificete has been signed by the ettending phy.<br>y the funeral director, page 2 should be detached for use as the | To Be Completed by Physician/Medical                       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as  Due to (or as  Due to (or as  Due to (or as  Due to (or as  Due to (or as  Due to (or as  Due to (or as  | a conseque a consequence of):  of pregnancy 2 Fetal death time of death  ut not resulting in the  | B   Ectopic preg   | 26. Place of Dother: 4 \( \text{ Nursing } \) Injury at Work? 1 \( \text{ Yes} \) 2 \( \text{ No} \)   | 23e. Did to  24a. Whs a  24a. Whs a  autop  perfor  1  Yes  Death Check only or  3 Home 5 Resid  28d. Describe h  | 23d. Date of delive Month  bacco use contribute to the set of the  | Day Year the cause of death? bably 4 □Unknow opsy findings availab ompletion of cause of 2 □ No   |
| death.<br>ctor: Afler this certificate has been signed by the ettending phy.<br>rthe funeral director, page 2 should be detached for use as the  | Certification: To Be Completed by Physician/Medical        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  Part II. Other significant conditions: 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigal 2 Accident 3 Suicide 6 Could no determine  29a. Certifier Certifying | Due to (or as  c  | a conseque  a consequence of):  of pregnancy 2 Fetal death time of death  ut not resulting in the  ut not resulting in the  pry y Year  28b. Time Injury ury - At home, farm, c. (Specify)  of my knowledge, def examination and/or | B Ectopic preg   | 26. Place of Dother: 4 \( \text{Nursing} \) Injury at Work? 1 \( \text{Yes} \) 2 \( No of the time, date and place the time time.   | 23e. Did to  24a. Whs a autoperfor 1 Yes  Death Check only or g Home 5 Resid 28d. Describe h  28f. Location (S City or Tow  | 23d. Date of delive Month  bacco use contribute to the set of the  | Day Year the cause of death? bably 4 □Unknow opsy findings availablompletion of cause of 2 □ No  ral Route Number,  |
| ugati<br>stor: Affer this certificate has been signed by the ettending phy:<br>r the funeral director, page 2 should be detached for use as the  | To Be Completed by Physician/Medical                       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as  C. Due to (or as  d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  B contributing to death b  28a. Date of Inju (Month, Date of Inju (Month, Date of Inju (Month))  28a. Date of Inju (Month)  28b. Place of Inju (Month)  28b. Place of Inju (Month)  28c. Place of Inju (Month)   | a conseque a consequence of):  of pregnancy 2 Fetal death time of death  ut not resulting in the lining of the lining of the lining of the lining of my knowledge, def examination and/or ated.                                     | B Ectopic preg Control of Street, factory, control of Street, factory, control of the street,  | other: 4 Nursing North N | 23e. Did to  24a. Was a autop: perfor 1 yes  Death Check only or g Home Sesid 28d. Describe h  28f. Location (S City or Tow ace, and due to the courred at the time, co         | 23d. Date of delive Month  bacco use contribute to the set of the  | the cause of death?  bably 4 □Unknown  opsy findings available  ompletion of cause of  2 □ No  offy)  al Route Number,  stated,  to the cause(s)                    |
| ss been signed by the ettending phy:<br>2 should be detached for use as the  | edical Certification: To Be Completed by Physician/Medical | IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  | Due to (or as  C. Due to (or as  d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown  s contributing to death b  28a. Date of Inju (Month, Date of Inju (Month) Date of | a conseque a consequence of):  of pregnancy 2 Fetal death time of death  ut not resulting in the linjungury - At home, farm, c. (Specify)  of my knowledge, def examination and/or ated.  | B Ectopic preg Compared to the compared to the | 26. Place of D Other: 4 \( \triangle | 23e. Did to  24a. Was a autop perfor  1  Yes  Death Check only or  3 Home 5 Resid  28d. Describe h  28f. Location (S  City or Tow  ace, and due to the occurred at the time, of | 23d. Date of delive Month  bacco use contribute to the service of  | baby Year  the cause of death?  bably 4 □Unknow  opsy findings availab  ompletion of cause of  2 □ No  ffy)  ral Route Number,  stated, to the cause(s)  Day, Year) |

|            |  |                  | Please I   | ype or Print in Bia  |  |   |  | _                                       |  |
|------------|--|------------------|--|--|--|---|--|---|--|
|            |  |                  | For<br>State<br>Registrar  | State of Maryland  | •  |   | ntal Hygien                                | e) 1115                                 | 22631  |
|            |  |                  |  |  | Certificate of D   |   | Reg. N                                     | <u> 0 0 0 0 </u>                        | 64001  |
|            | Physici<br>/Medi   |                  | 1. Decedent's Name (First, Middle, Last)   | MAHA   | IFFey  | _   | Date of Death Month Di                     | 9 2006                                  | 3. Time of Death                             |
| 1          | Examir   |                  | 4a. Facility Name (If not institution, give s  | St. Apt. 4   | 4b. City, Town, or L   | ocation of Death                          | ints A                                     | c. County of Death                      | Seomes                                       |
|            | Funeral<br>Director  |                  | 5. Social Security Number 6. Sex   |  | birthday) If Under 1 Year Months Days  | If Under 24 Hrs. 8.<br>Hours Min.         | Date of Birth<br>(Month, Day, Year         | 9. Birthe Cou/                          | place (State of Foreign                      |
|            | ehow   |                  | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, T   | own or Location  | i ı                                       | 7  | 1                                       | Od. Inside City Limits                       |
|            | the Mar  | rector           | md. Prince (   | searges Dis  | trict Hei  | ights                                     | 10g. C                                     | itizen of What Cou                      | 1 Z Yes 2 □ No                               |
|            | eath with  | Funeral Director | 6700 Alpine  | St. #4  12. Was Decedent Ever in U.S.  | 30   | 747                                       |  | USA                                     |  |
| 036        | ges 1 end 2 should be filed within 72 hours after death with the Maryland it of Heelih and Mental Hygiene.  If Itam 27 ie marked other then "natural", or Items 23a or 28e-f ehow or other treumatic event, the Middeal Examinar must be inclined at | by               | 1 Never Married 2 Married 3 Widowed 4 Divorced   | Armed Forces?  1 Tyes 2 No If Yes, Give Year or Dates:   | 13. Was Decedent of Hisp<br>If Yes, specify Cuban,<br>1 ☐ Yes 2 ☐ No                       | Mexican, Puerto Ric                       | an, etc.)                                  | 14. Race - Americ<br>Black, White,      |  |
| 21215-0036 | within 72 ho<br>ene.<br>then "natui<br>the Medical   | Completed        | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)                              | cation 1<br>completed) College (1-4or 5+)  | 6a. Decedent's Usual Occupatii<br>(Give kind of work done dur<br>life. DO NOT use retired) | on<br>ring most of working                | 16b. I                                     | Kind of Business/In                     | dustry                                       |
|            | filed with<br>Hygiene.<br>other ther   | Con              |  | 2+   | school 134   | S Drive                                   | er C                                       | overn                                   | ment   |
| Maryland   | 2 should be filed withir<br>and Mental Hygiene.<br>ie marked other then<br>eumatic event, tre Ma   | To Be            | 17. Father's Name (First, Middle, Last) Le Rue Me  | c Gee  | 1  | 8. Mother's Name (F)<br>Ruth              | irst, Middle, Maide<br>Ma                  | haffe                                   | $\checkmark$                                 |
|            | and 2 sho<br>eith and i<br>27 ie ma<br>er treuma   |                  | 19a. Informant's Name/Relationship (Typ. Steven C. Mah   | afferison  | 9b. Mailing Address (Street and  | d Number or Rural Ro                      | oute Number, City                          | or Town, State, Zip                     | 1 Md.  |
| Baltimore, | Peges 1 ent of He  |                  | 20a. Method of Disposition  1 Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)                            | / 00000  | of Disposition (Name of atery, crematory or other place)                                   | 7/0(a                                     | 101 Ch                                     | ocation - City or To                    | own, State                                   |
| Baltin     | perrit. Peges 1 end 3<br>Department of Heelth<br>Importent: if Itam 27<br>any injury or other tr.<br>once.   |                  | 21. Signature of Funeral Service License   | e Deli   | 22. Name and Address   | of Facility                               | schur G                                    | EITENNAU<br>- 111715 1/1                | my ma.                                       |
|            | _  | -                | 23a. Part1. Enter the disease, or complice shock, of heart failure. List only on                               | cations that caused the death.   | o not enter the mode of dving.   | such as cardiac or re                     |  | - NOW W                                 | Uh, DC<br>Approximate                        |
| J          | Physician  |                  | shock, of heart failure. List only on<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | e cause of each line.  CART  | IAC AR   | REST                                      |  | b                                       | Interval Between<br>Onset and Death          |
|            | /Medical<br>Examiner   |                  | Sequentially list conditions   | CORONA   | RY ATER  | V DISE                                    | EASE                                       |   | Vears  |
|            | cuted<br>nd<br>ransit  | Examiner         | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events            | Due to (or as a consequent   | ce of):/   | (   |  |   | (  |
| 760,       | ate be executed<br>nysicien and<br>he burial-transit   | cai Ex           | resulting in death) Last   | Due to (or as a consequent   | ce of):  |   |  |   |  |
| 99         | ertificat<br>ling phy<br>e as th   | Medi             | IF FEMALE:   |  |  |   |  |   |  |
| P.O. Box   | ires that the death certifical<br>signed by the attending phy<br>d be detached for use as th   | Physician/Med    | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  | 3c. If yes, outcome of pregnancy<br>1 ☐ Live birth 2 ☐ Fetal dea<br>4 ☐ Pregnant at time of death<br>9 ☐ Unknown | ath 3 Ectopic pregnancy  |   |  | 23d. Date of delive<br>Month            | nry<br>Day Year                              |
|            | The law requires that the death certifica<br>ste has been signed by the attending ph<br>page 2 should be detached for use as th  | ed by Pł         | Part II. Dther significant conditions con  | tributing to death but not resultin  | g in the underlying cause given  | in Part I.                                |  | use contribute to th                    |  |
| I Records, |  | Completed by     | ( 1  |  |  |   | 24a. Was an autopsy performed?             | prior to cor<br>death?                  | psy findings available inpletion of cause of |
| of Vital   | Physiclan:<br>r this certificatal director,  | Be               | 25. Was case referred to medical exampler?   | o o citali   | 0.4  | 6. Place of Death C                       | heck on one                                |   |  |
| of         | Phyer<br>this<br>ral dir   | - To             | 1 ☑Yes 2 ☐ No ☐' 27. Manner of Death   |  |  | 4 Transing Home                           | 5 Describe how inju                        |   | )  |
| ion        | Attending I<br>rr death.<br>ector: After<br>by the funer   | ation            | Natural 5 Pending 2 Accident investigation   | (Month, Day Year)  | Injury Work?   | s 2 □ No                                  | Describe now mig                           | ry occurred                             |  |
| Division   | el or Atte<br>s efter de<br>si Directo   | Certification;   | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At home, building, etc. (Specify)   | farm, street, factory, office  | 28f.                                      | Location (Street a.<br>City or Town, State | nd Number or Rura<br>e)                 | l Route Number,                              |
|            | To the Hospitel or Attending Phwithin 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral  | Medical C        | 29a. Certifier 1 Certifying Phys (Check only one)  | ician: To the best of my knowled<br>ler; On the basis of examination<br>and manner stated.                       | dge, death occurred at the time, and/or investigation, in my opin                          | date and place, and ion, death occurred a | due to the cause(s<br>t the time, date an  | and manner as st<br>d place, and due to | ated.<br>the cause(s)                        |
|            | To th<br>within<br>To th<br>compl  | Me               | 29b. Signature and title of certifier  | 1100-  | 29c. License п   | umber                                     | 29d. Da                                    | te signed (Month, I                     | Day, Year)                                   |
| Ĺ          |  |                  | MISTUR   | /allibras  | MD2  | 5280                                      | 0  | 7-01-                                   | 2006   |
| R          | -(10)  |                  | 30. Name and address of person who con   | mpleted cause of death (Item 23)   | MD2:<br>8 Southern   | Ave SE.                                   | Wash                                       | instan i                                | DC 26037.                                    |
|            | Sta<br>Registr   | -                | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signature  | pode   |   |  | J                                       |  |

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|             |  |                    |   | State of Marylar   | -                                       | tificate of  |   | R                                       | leg. No.                          | 106                          | 22632  |
|-------------|--|--------------------|---|--|---|--|---|---|-----------------------------------|------------------------------|--|
|             | Physiciar<br>/Medica   | 1                  | Decedent's Name (First, Middle, Last)     MARY M M  | JRPHY  |   |  |   | 2. Date of Dea<br>June<br>June          | _                                 | 2006                         | 3. Time of Death 3:45 PM                                 |
| لجامد       | Examine  | •                  | 4a Fecility Name (If not institution, give s<br>Larkin-Chase Hea  |  |   |  | 4b. City, Town, or Bowie                              | Location of Deeth                       | 4c. County<br>Prince              |                              | rge's  |
|             | Funeral<br>Director  | L                  |   | 7. Age (In yrs. 82   | last birthday)<br>Yrs.                  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                        | 8. Date of Birth<br>June 3,             | 1924                              | 9. Birthpl<br>Count<br>Penns | ace (State or Foreign<br>Y)<br>Ylvania                   |
|             | e Maryland<br>ta-f show  |                    | Usuel Residence of Decedent  10a. State 10b. County  Maryland Prince (  |  | ty. Town or Lo<br>wie                   | cation   |   |   |                                   | 10                           | od. Inside City Limits                                   |
|             | 3a or 28   | II Dire            | 10e. Street end Number<br>14997 Health Cent   | er Drive   |   | 10f. Zip Code 20716  |   | 1                                       | 0g. Citizen of V                  | Whet Count                   | ry?  |
| 020         | permit. Pages 1 and 2 should be lited within 72 hours after death with the Maryland Department of Health and Mantal Hygiena. Department of Health and Mantal Hygiena.  Bright in the Maryland of the transport of the Maryland Evaning must be notified at once.  To Be Completed by Europe Director.  | Dy Funera          | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | 2. Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 24≦ No<br>If Yes, Give<br>Year or Dates: |   | Vas Decedent of f<br>Yes, specify Cub                                  | dispanic Origin? (S<br>an, Mexican, Puert<br>Specify: | pecify Yes or No-<br>o Rican, etc.)     | 14. Rac<br>Blac                   | ce - America<br>ck, White, e | tc.  |
| 21215-0020  | within 72 ho<br>jiena.<br>r than "natur<br>the Medical.  | pasaiduio          | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   | cation<br>completed)<br>College (1-4or 5+)   | (Give<br>life. L                        | lent's Usual Occup<br>kind of work done<br>DO NOT use retire<br>Keeper | petion<br>during most of wor<br>d)                    | sity<br>land                            | OI                                |                              |  |
| Maryland 3  | Antal Hygrand  | 200                | 17. Fether's Neme <i>(First, Middle, Last)</i><br>George Matais   |  | -                                       | *  | 18. Mother's Nam<br>Frances                           | ne (First, Middle, 1<br>Durdek          | Maiden Surnan                     | 10)                          |  |
| , Mary      | and 2 shows all the and N 27 la mail to the mail to th |                    | 19a. Informant's Name/Relationship (Ty)<br>George Murphy – So   |  | and Number or Ru<br>Parkway,            |  |   |   |                                   |                              |  |
| Baltimore,  | Fages 1:<br>nent of He<br>ant: If Item<br>ury or oth   |                    | 20a. Method of Disposition  1 Durial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)   |  | Place of Disponentery, crem<br>te of H  | sition (Name of<br>natory or other pla                                 | се)   | 7/3/06 S                                | 20c. Location -                   | City or Tov                  | vn, State  |
| Balt        | permit,<br>Departr<br>Importu<br>any inji  |                    | 21. Signature of French License   | Lone -   | 90]                                     | Name and Address<br>ndon/Hal<br>3 Annapo                               |   |   |                                   |                              | 20706  |
|             | Physician<br>/Medical<br>Examiner  | 5                  | 23a. Part Enter the disease, or complish ck, or heart failur List of the list | SEPSIS   | ch. Do not ente                         |  | ng, such as cardiac                                   | or respiratory arm                      | est,                              |                              | Approximate<br>Interval Between<br>Onset and Death       |
| ( 68/60,    | Into law requires that the deam certificate be executed at a has been signed by the attending physician and page 2 should be detached for use as the bunal-transit completed by Physician/Medical Examiner   | medical Evalilli   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | r as a consequ                          |  |   |   |                                   |                              |  |
| s, P.O. Box | ires that the death certification is signed by the attending do be detached for use a by Dhysician/M   | y r mysician       | Part II. Other significant conditions con<br>Clostridium Det  |  |   | derlying cause giv   | ven in Part I.  |   | bacco use co                      |                              | the cause of death?<br>ably 4 ☐ Unknown                  |
| Hecords,    | rine law requires sata has been sig, page 2 should b   | name of the second |   |  |   |  |   | 24a. Was e<br>perform                   | n autopsy<br>ned?                 | avai<br>com<br>of de         | e autopsy findings lable prior to pletion of cause eath? |
| or Vita     | his cartifical director,   | 3                  | 25. Was case referred to medical examiner?  1 Yes ENNo  27. Menner of Deeth  Natural 5 Pending 2 Accident investigation   | ospital: 1 ☐ Inpatient 2 🖔<br>28a. Date of Injury<br>(Month, Dey Year)                         | ER/Outpatient<br>28b. Time of<br>Injury | 28c. Inju  | er: 4 Nursing H                                       | ome 5 Reside                            | ence 6 Othe                       |                              |  |
| -           |  |                    | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At he building, etc. (Specif  | y)<br>                                  |  |   | 28f. Location (St.<br>City or Town      | , State)                          |                              |  |
|             | within 24 hours after To the Funeral Dir. completely filled in Medical Cert  |                    | 29a. Certifier (Check only one) 1 Certifying Physical Examin  | cisn: To the best of my kno<br>er: On the basis of examina<br>and manner stated.               | wledge, deeth<br>tion end/or inv        | occurred at the tire<br>estigation, in my o                            | ne, date end place<br>pinion, death occur             | , and due to the carred et the time, da | use(s) and ma<br>ate and place, a | nner as sta<br>and due to t  | ted.<br>he cause(s)                                      |
|             | within vithin comp   |                    | 29b. Signature and title of contilier   | Mess   |   | 29c. Licens  | e number<br>3351                                      | 29                                      | June                              |                              |  |
| 2           | (10)   |                    | 30. Neme and eddress of person who cor<br>Dr. Ikechi Fred Okw   | npleted cause of death (Item<br>ara, 6201 Gre  | n 23e) (Type, F<br>eenbelt              | Print) Road, C   | ollege Pa   | ark, Mar                                | vland '                           | 20740                        |  |
|             | State<br>Registrar   |                    | 31. Dete filed (Month, Day, Year)   | 32. Registrer's Signa  |   |  |   | ,                                       |                                   | _0,10                        |  |

|            |   |                   | For<br>State<br>Registrar   |                          | State o                  | of Mai                  | rylan           | d / Depa                    |                | nt of H<br>te of L                       |            |              | lental        |                             | ene<br>. <sub>No.</sub> 2 ( | 006                       | 22633                                   |
|------------|---|-------------------|---|--------------------------|--------------------------|-------------------------|-----------------|-----------------------------|----------------|--|------------|--------------|---------------|-----------------------------|-----------------------------|---------------------------|---|
| in the     |   |                   | 1. Decedent's Name (First, Mi   | ddle, Last)              |                          |                         |                 |                             |                |  |            |              | 2. Date Monti |                             | Day                         | Year                      | 3. Time of Death                        |
|            | Physicia<br>/Medic  |                   | Jon Alex Mc   | Kinstı                   | <b>.</b> y               |                         |                 |                             |                |  |            |              | Ju13          | 7 5,                        | 2006                        |                           | 12:47AM                                 |
| 1          | Examin  | er                | 4a. Facility Name (If not institu   |                          | reet and nu              | imber)                  |                 |                             |                | , Town, or                               |            | n of Death   |               |                             |                             | ity of Death<br>erick     | 1                                       |
| - 20       |   |                   | 109 Andover C 5. Social Security Number   | ourt<br>6. Sex           |                          | 7. Age                  | (In vrs. I      | ast birthday)               |                | erick<br>er 1 Year                       |            | er 24 Hrs.   | 8. Date       | of Birth                    |                             | 9. Birth                  | place (State or Foreign                 |
|            | <ul><li>Funeral</li><li>Director</li></ul>  |                   | 156-30-6965   |                          | M 2□F                    |                         | 66              | Yrs.                        | Months         | Days                                     | Hours      | Min.         | Mar           | h, Day, Y                   |                             |                           | <sub>intry)</sub><br>sylvania           |
| 27         | D.  |                   | Usual Residence of Decedent   |                          |                          |                         |                 | , Town or Lo                |                |  |            |              |               |                             |                             |                           | 10d. Inside City Limits                 |
|            | arylar<br>show  | _                 | 10a. State 10b. Cou   |                          |                          | 1                       | _ ′             |                             |                |  |            |              |               |                             |                             |                           | 1 ☐ Yes 2√E No                          |
|            | 28a-f   | ecto              | Maryland Mont   | gomer                    | У                        |                         | Gern            | nantow                      |                | ip Code                                  |            |              |               | 100                         | a. Citizen o                | f What Cou                |   |
|            | with<br>Be or   | 2                 | 19951 Appledow  | re Ci                    | rc1e                     |                         |                 |                             | 208            |  |            |              |               | U                           | SA                          |                           |   |
|            | 4 within 72 hours after death with the Maryland<br>liene.<br>r than "natural", or iteme 23a or 28a-f show<br>the Medical Exant in frout the motified at | Funeral Directo   | 11. Marital Status  |                          | 2. Was Dec               | edent E                 | ver in U.       | S. 13.                      | Was Dec        | edent of Hi                              | ispanic (  | Origin? (Spe | ecity Yes     | or No-                      |                             | ace - Amer<br>lack, White | ican Indian,                            |
| 9          | or its  |                   | 1 Never Married 2 🕅 N   | Married                  | 1 XYes                   | 2 🗆 No                  | ·               |                             | 1 ☐ Yes        |  | Specif     |              | ritoditi, ot  | J.,                         | į.                          | oify: Whi                 |   |
| 21215-0036 | urai',  | d by              | 3 Widowed 4 Divor   |                          | If Yes, Gi<br>Year or D  | Dates 9                 | 5/-6            | 50                          |                |  |            |              |               | 16                          |                             | Business/li               |   |
| 15         | n 72 h  | Completed         | (Specify only hig   | T                        | completed)               |                         |                 | 16a. Dece<br>(Give<br>life. | kind of w      | ual Occupi<br>rork done d<br>use retired | durina m   | ost of work  | ing           | 10                          | D. KIIIG OI                 | Dusinessin                | nodstry                                 |
| 12         | iene.<br>r than "   | отр               | Elementary/Secondary (0-1   | 2)                       | College (                | (1-4or 5+               | -)              | Coal :                      | Mine           | c  |            |              |               | M                           | ining                       |                           |   |
| b          | \$ 5 E  | Be C              | 17. Father's Name (First, Mide  | de, Last)                |                          |                         |                 | ·                           |                |  | 18. Mo     | ther's Name  | e (First, M   | liddle, Ma                  | iden Sum                    | ame)                      |   |
| /lar       |   | ToE               | Roy Thomas Mcl  | Cinstr                   | У                        |                         |                 |                             |                |  |            | lotte        |               |                             |                             |                           |   |
| Maryland   | s 1 and 2 should be f<br>Health and Mental b<br>Item 27 is marked of<br>other traumatic eve   |                   | 19a. Informant's Name/Relati  |                          |                          | : f c                   |                 | 4                           | -              |  |            | Circl        |               |                             |                             |                           |   |
|            | 1 and 2<br>Health<br>em 27 i  |                   | Rosemarie M. N  | ickins                   | try/w                    | TIE                     | 20b. P          | Place of Disp               | osition (N     | ame of                                   |            |              | Date          | -                           |                             |                           | Town, State                             |
| יסר        | ages<br>nt of h   |                   | 1 ☐ Burial 2 🗷 Cremati  |                          | moval from               | State                   | 0               | emetery, cre<br>esapea      | matory or      | other plac                               |            | 07/0         | 16/06         | - 1                         |                             |                           | Maryland                                |
| Baltimore, | permit. Pages 1<br>Department of H<br>important: If ite<br>any injury or ot<br>ance.  |                   | 4 □ Donation 5 □ Othe  21. Signature of Funeral Serv  |                          | 8/0                      | , ,                     | Cne             |                             |                |  |            |              |               |                             |                             |                           | x 784                                   |
| Ba         | Depa<br>impo<br>eny i   |                   | Dane la   | L.                       | Lot                      | the                     | MO12            | 251 B                       | oıng<br>ever   | Home                                     | Hec        | krott        | e. P          | .A.                         | e r.<br>Clark               | svill                     | e, MD 21029                             |
|            |   |                   | 23a. Part1. Enter the disease shock, or heart failure.  | , or complic             | ations that              | caused in               | the deat        |                             |                |  |            |              |               |                             |                             |                           | Approximate<br>Interval Between         |
|            | Physician   |                   | Immediate Cause (Final disease or condition   |                          |                          |                         |                 | 11 Lun                      | g Ca           | ncer                                     |            |              |               |                             |                             |                           | Onset and Death  1 month                |
|            | /Medical  |                   | resulting in death)   |                          | Due to                   | (or as a                | conseq          | uence of):                  |                |  |            |              |               |                             |                             |                           |   |
| 水電         | Examiner  | _                 | Sequentially list conditions,   | b.                       | Squam                    | ous                     | Ce1             | 1 Canc                      | er o           | f Lun                                    | ıg         |              |               |                             |                             |                           | 1 month                                 |
|            | led<br>sit  | Examine           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | <                        | D00 10                   | (01 as a                | COIISEQ         | derice or).                 |                |  |            |              |               |                             |                             |                           |   |
|            | and al-trar   | xan               | that initiated events<br>resulting in death) Last   | C.                       | Due to                   | o (or as a              | conseq          | uence of):                  |                |  |            |              |               |                             |                             |                           |   |
| 8760       | ate be executed hysician and the burial-transit   |                   |   | <b>U</b> d.              |                          |                         |                 |                             |                |  |            |              |               |                             |                             |                           |   |
| 9          | death certificate be executed<br>e attending physician and<br>of for use as the burial-transit  | Physician/Medical | IE ESMALE.  |                          |                          |                         |                 |                             |                |  |            |              |               |                             |                             |                           |   |
| 30X        | Jeath certifica<br>attending ph<br>I for use as t   | an/h              | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?  | 23                       | 3c. If yes, or<br>1□Live | utcome of               |                 | death 3                     |                | pregnancy                                | У          |              |               |                             |                             | Date of deli              | very<br>Day Year                        |
| O. B       | e dea<br>the at<br>hed fo   | sici              | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   |                          | 4∐Preg<br>9∐Unki         | gnant at i<br>nown      | time of d       | leath 5                     | Other (        | specify)                                 |            |              |               |                             |                             |                           |   |
| ٥.         | The law requires that the de<br>ate has been signed by the a<br>bage 2 should be detached   | Ph)               | Part II. Other significant con  | ditions con              | tributing to             | death bu                | t not res       | ulting in the               | underlying     | cause giv                                | ren in Pa  | rt I.        | 23e           | . Did toba                  | cco use c                   | ontribute to              | the cause of death?                     |
| Records,   | uires tha<br>signed<br>Id be del  | d by              | •   |                          |                          |                         |                 |                             |                |  |            |              |               | 1 🗆 Yes                     | 2 □ No                      | 3 🗆 Pro                   | obably 4 DUnknown                       |
| cor        | w requir<br>been s  | ete               |   |                          |                          |                         |                 |                             |                |  |            |              | 24a           | . Was an                    | 24                          | b. Were au                | topsy findings available                |
| Re         | The lav   | Completed         |   |                          |                          |                         |                 |                             |                |  |            |              | 10            | autopsy<br>perform<br>Yes 2 | ed?<br>X No                 | death?                    | completion of cause of<br>2 No          |
| Vital      |   | 0                 | 25. Was case referred to me   | dical                    |                          |                         |                 |                             |                |  | 26. Pl     | ace of Deat  |               |                             |                             |                           |   |
| Ţ          | Physicien:<br>r this certific<br>ral director,  | To B              | examiner?<br>1 ☐ Yes 2 ☑ No   | Н                        | -                        | Inpatier                |                 | ER/Outpatie                 | ent 3          |  |            | Nursing Ho   |               |                             |                             |                           | daughters<br>home                       |
| n of       | ding Ph<br>h.<br>After th<br>funeral  |                   | 27. Manner of Death<br>1 ☑ Natural 5 ☐ Pe   | nding                    | 28a. Date<br>(Mo         | e of Injur<br>onth, Day | Year)           | 28b. Time<br>Injury         |                | 28c. Injur<br>Wor                        |            |              | 28d. Des      | cribe hov                   | v injury occ                | curred                    |   |
| sio        | Attanding r death. ector: After by the fune   | cat               | 2 Accident inv  | estigation<br>uid not be | 29a Blad                 | oo of Iniu              | ny - At h       | ome, farm, s                | M<br>troot fac |  | Yes 2      | □No          | 28f Loca      | tion (Stre                  | et and Nu                   | mber or Ru                | ıral Route Number,                      |
| Division   | or At<br>after of<br>Direction by   | Certification:    | 4 Homicide  | benimet                  | buil                     | ding, etc               | . (Speci        | fy)                         | lieel, iac     | ory, omce                                |            |              | City          | or Town,                    | State)                      |                           | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| _          | To the Hospital or Attency, within 24 hours after death To the Funeral Director: completely filled in by the  |                   | 29a. Certifier 1X Cert  | ifying Phys              | icien: To th             | ne best o               | of my kno       | owiedge, dea                | ith occurr     | ed at the tir                            | me, date   | and place,   | and due       | to the car                  | use(s) and                  | manner as                 | stated.                                 |
|            | Me Ho   | Medical           | (Check only 2 Med<br>one)   | ical Exemir              | er: On the<br>and ma     | basis of<br>inner sta   | examina<br>ted. | ation and/or i              | nvestigati     | on, in my c                              | opinion, o | death occur  | red at the    | time, da                    | te and plac                 | e, and due                | to the cause(s)                         |
|            | To the Vithin 2 To the complet  | Σ                 | 29b. Signature and title of ce  | rtifier                  | 1100                     |                         | _               | ^                           |                | 29c. Licens                              |            | ər           |               |                             |                             |                           | h, Day, Year)                           |
|            | 2   |                   | > Joseph  | km-                      | 17/166                   | ent                     | 41              | no                          |                | D3240                                    | )/         |              |               | J                           | uly 5                       | 200                       | ס <i>ו</i>                              |
| 4          | -100L   |                   | 30. Name and address of pe  |                          |                          |                         |                 |                             |                |  |            | 11.000 -     | D 1           | •                           | M.                          | 20050                     |   |
| 1          | 0.6   | 040               | Joseph M. Hag   | gerty:                   | M.D.                     | Redistra                | ar's Sign       | edical                      |                |  | Jr.        | #300_I       | Kocky         | итте                        | , MD                        | 20850                     | )                                       |
|            | St<br>Regist  | ate<br>trar       | JUL   | 6 2                      | 006                      | Flore                   | w               | J.                          | Coon           | 2  |            |              |               |                             |                             |                           |   |

06-04570 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Harold Glenn Martin 1. For State Certificate of Death Rea No Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day June 29, 2006 1231 hrs Harold Glenn Martin Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthp Washington If Under 1 Year If Under 24Hrs 5 Social Security Number 7. Age (In yrs last birthday) **Funeral** Min 02-28-1958 Months Hours Davs Director Country) 214-76-8526 1 X M 2 Yrs Usual Residence of Decedent 10d Inside City Limits 10a State 10c. City. Town or Location È Yes 2 X No or 28a-f show Owings Calvert MD after death with the Maryland 10g. Citizen of What Country 10f. Zip Code 10e. Street and Numbe notified at USA 20736 2611 Manor Court 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 8lack Funeral 12. Was Decedent Ever in U.S. Marital Status nust be Armed Forces? White etc. 1 Never Married 2 X Married 2 X No Yes White f Yes, Give Year 1 Yes 2 X No specify: Widowed Divorced ş 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) es 1 and 2 should be filed within 72 l of Health and Mental Hygiene
If item 27 is marked other than "... marked other than event, the Medical Baltimore, MD 21215-0036 Roofing Project Manager 18 Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Phyllis Freeman Be Harold V. Martin 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 18 Owings, MD 20736 Stephanie Martin (wife) 2611 Manor Court 27 item 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place nt: If i 1 X Burial 2 Cremation 3 X Removal from State perm.
Departmen.
Important: If July 7 2006 Christchurch, VA Christ Church Cem. Donation 5 Other Specify. 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signal Funeral Service Licensee Owings, MD 20736 8125 Southern Maryland Blvd. J. Gold wary 23a Part | Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical AMENDED UNPENDED attending physician or use as the burial -Box 68760, he death certificate be e 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I P.O. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, 24a Was an 24b. Were autopsy findings available peen prior to completion of cause of autopsy After this certificate has death? performed? ✓ Yes 2 1 V Yes 26 Place of Death (Check only one) inneral director, 25. Was case referred to medical To the Hospital or Attending Physician: Division of Vital Be Other<sub>4</sub> DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day Year Jun 29, 2006 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject fell from roof 1145 hrs Natura 1 ✓ Yes 2 Pending after death the Director: 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State determined 3900 Penn Belt Place Place, Forestville, MD (Specify) Industrial Area within 24 hours a To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d Date signed (Month, Day, Year) 29c License numbe 29b Signature and title of certifier O.C.M.E. June 30, 2006 aud 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD.

36

istrar's Signatur

State Registra

31 Date filed (Month Pay,

°0° 6 2006

|                     |   | -                   | For State Registrar  | State of Ma                           | ryland / Depa<br><i>Cei</i>           | artment of H                                  |                                |                                  | iene<br><sub>eg. No.</sub> 2006 | 22635   |
|---------------------|---|---------------------|--|---------------------------------------|---------------------------------------|---|--------------------------------|----------------------------------|---------------------------------|---|
|                     |   |                     | Decedent's Name (First, Middle, Last)  |                                       | <del>-</del> -                        |   |                                | 2. Date of Dear                  | th                              | 3. Time of Death                                |
|                     | Physicia  |                     | Harry Joseph Mu  | mmer                                  |                                       |   |                                | June 27                          | <sup>2</sup> 2006               | 7:00 P M  |
|                     | /Medic<br>Examin  |                     | 4a. Facility Name (If not institution, give str                                  | eet and number)                       |                                       | 4b. City, Town, or                            | Location of Death              |                                  | 4c. County of Deat              | h   |
| 1                   | Examin  | Ŭ.                  | Shady Grove Advent   | ist Hosp                              | ital                                  | Rockv   | ille                           |                                  | Montgome                        | ry  |
|                     | Funeral   |                     | 5. Social Security Number 6. Sex   |                                       | (In yrs. last birthday)               | If Under 1 Year<br>Months Days                | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day) | Year) 9. Birt                   | hplace (State or Foreign untry)                 |
| П                   | Director  |                     | 180-18-3033  | 1 2□F                                 | 83 Yrs.                               | Wilding Day C                                 | 1100.0                         | Nov. 2                           |                                 |   |
|                     | D .   | }                   | Usual Residence of Decedent  10a. State 10b. County                              |                                       | 10c. City, Town or Lo                 | cation  |                                |                                  |                                 | 10d. tnside City Limits                         |
|                     | ehov  | ក                   | MD Montgome  | r37                                   | •                                     | Germantow                                     | m                              |                                  |                                 | 1 ☐ Yes 2 No                                    |
|                     | Z8a-f   | ect                 | 10e. Street and Number   | 1 y                                   |                                       | 10f. Zip Code                                 | /11                            | 1                                | 0g. Citizen of What Co          | untry?  |
|                     | with a or   | 급                   | 19751 Crystal Rock   | Drive A                               | ot 14                                 |   | 1874                           |                                  | United S                        |   |
|                     | ne 23   | era                 | •  | . Was Decedent E                      | •                                     | Was Decedent of Hi<br>f Yes, specify Cuba     |                                | ecify Yes or No-                 | 14. Race - Ame                  | rican tndian,                                   |
| Maryland 21215-0036 | be filed within 72 hours after death with the Maryland tal hygiene.  id other then "naturel", or items 23a or 28a-f ehow event, the Masilcal Exeminar most be notified at | by Funeral Director | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced                           | Armed Forces?<br>1 ØYes 2 ☐ No        | 0                                     | fYes, specify Cuba<br>1 ☐ Yes 2 🛣 No          | Specify:                       | Rican, etc.)                     | Black, White                    | White   |
| Š                   | 2 hou   | ted                 | 15. Decedent's Educa   |                                       | 16a. Dece                             | dent's Usual Occupa                           | ation                          |                                  | 16b. Kind of Business/          | Industry  |
| 75                  | hin 7.  | Completed           | (Specify only highest grade of Elementary/Secondary (0-12)                       | College (1-4or 5-                     | life.                                 | DO NOT use retired                            | )                              | mg                               |                                 |   |
| 2                   | e filed within al Hygiene. I other then "   | PO.                 | 12   |                                       |                                       | my/Navy                                       |                                |                                  | Military                        |   |
| 덜                   | be filed<br>ital Hygi<br>of other<br>evant,   | Be (                | 17. Father's Name (First, Middle, Last)  |                                       |                                       |   | 18. Mother's Nam               |                                  | _                               |   |
| <u>a</u>            | Ment<br>Ment<br>arked   | 2                   | Harry Mumma  |                                       |                                       |   | Emr                            |                                  |                                 |   |
| and in              | 2 should be<br>and Mental<br>is marked<br>raumatic ev   | 0 3                 | 19a. Informant's Name/Relationship (Type   |                                       |                                       |   |                                |                                  | r, City or Town, State, 2       |   |
|                     | and<br>ealth<br>m 27  |                     | Susan Dowd / Daugh   | ter                                   | 19/61<br>20b. Place of Dispo          |   |                                |                                  | 23, German                      |   |
| 9                   | T T T   |                     | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ref                      | moval from State                      | cemetery, crei                        | natory or other plac                          | e)   .Τ11.1.y                  |                                  | Germantwo                       |   |
| Ē                   | g en in in  |                     | 4 □Donation 5 □Other (Specify)   |                                       |                                       | s Cemeter                                     | J                              |                                  |                                 | <u> </u>  |
| Baltimore,          | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic engage.                                      |                     | 21. Signature of Funeral Service Licensee  | Cro                                   | 24                                    | Name and Address Deer Parl                    | D                              | eVol Fur<br>Gaithers             | neral Home,<br>sburg, MD 2      | 10 East<br>0877                                 |
|                     |   |                     | 23a. Part1. Enter the disease, or complications, or heart failure. List only one | tions that caused cause on each line  | the death. Do not ent<br>3.           | er the mode of dyin                           | g, such as cardiac             | or respiratory arr               | est,                            | Approximate<br>Interval Between                 |
| 4                   | Priysician  | 8                   | Immediate Cause (Final disease or condition                                      | MRSA                                  | Sepsis                                |   |                                |                                  |                                 | Onset and Death                                 |
|                     | /Medical<br>Examiner  |                     | resulting in death)  | Due to (or as a                       | consequence of):                      |   |                                |                                  |                                 |   |
|                     | LAdiminei   | ų.                  | Sequentially list conditions, b.   | Due to for as a                       | consequence of):                      |   |                                |                                  |                                 |   |
|                     | pe tist   | nine                | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury    | Due to (or as a                       | consequence on).                      |   |                                |                                  |                                 |   |
|                     | and al-trar   | Exami               | that initiated events c. resulting in death) Last                                | Due to (or as a                       | consequence of):                      |   |                                | -                                |                                 |   |
| 8760,               | cate be executed<br>physicien and<br>the burial-transit   | dica!               |  |                                       |                                       |   |                                |                                  |                                 |   |
| 687                 | ficate<br>p physics the   | edic                | d.   |                                       |                                       |   |                                |                                  | T. U                            |   |
| Вох                 | requires that the death certific<br>een signed by the attending p<br>nould be detached for use as i   | Physician/Me        | IF FEMALE: 23b. Was decedent pregnant 23c  | . If yes, outcome                     |                                       | Tetonio evenence                              |                                |                                  | 23d. Date of del                | ivery   |
|                     | death<br>e atte   | cia                 | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 1□Live birth 4□Pregnant at            |                                       | <pre>DEctopic pregnancy Other (specify)</pre> |                                |                                  | Month                           | Day Year  |
| P.0                 | by the  | hys                 | 9 Unknown  | 9□ Unknown                            |                                       |   |                                |                                  |                                 |   |
|                     | es that<br>igned to<br>be det   |                     | Part II. Other significant conditions control  Severe Aortic                     | •                                     | t not resulting in the u              | nderlying cause give                          | en in Part I.                  |                                  | bacco use contribute to         |   |
| bro                 | been si   | De le               | Devele Moltit  |                                       |                                       | <del></del>                                   |                                | 1 □ Y                            | es 2 No 3 Pr                    | obably 4 🕅 Unknown                              |
| 3                   | as be   | Completed by        |  |                                       | · · · · · · · · · · · · · · · · · · · |   |                                | 24a. Was a<br>autop:             | an 24b. Were as                 | topsy findings available completion of cause of |
| H.                  | The law cate has be page 2 s  | Son                 |  |                                       |                                       |   |                                | perfor<br>1 ☐ Yes                | med? death?<br>2⊠No 1 ☐ Yes     | 2 No  |
| ita                 | sicien: The   | Be (                | 25. Was case referred to medical examiner?                                       |                                       |                                       | Tau   | 26. Place of Deal              |                                  |                                 |   |
| 7                   | Physic<br>this call dire  | ၉                   | 1 ☐ Yes 2 🛣 No   | spital: 1 XInpatie                    |                                       |   |                                |                                  | ence 6 □Other (Spe              | cify)   |
|                     | Attending Physicien: r death. ector: After this certification the funeral director.   | Ë                   | 27. Manner of Death 1 ⊠Natural 5 □ Pending                                       | 28a. Date of Injur<br>(Month, Day     | Year) 28b. Time o<br>Injury           | Wor   |                                | 28d. Describe h                  | ow injury occurred              |   |
| Sign                | death.<br>ctor: A<br>y the fu   | cat                 | 2 Accident investigation 3 Suicide 6 Could not be                                | 20a Dlaga of tais                     | ry - At home, farm, st                |   | Yes 2 □No                      | 20f Location (S                  | treet and Number or Ri          | iral Pouta Number                               |
| -                   | after death   | Certification:      | 4 Homicide determined  | building, etc                         | . (Specify)                           | reet, ractory, onice                          |                                | City or Tow                      | n, State)                       | mai riodie ivalliber,                           |
| <b>□</b>            | Hospital Hospital Hours a Funerei (   |                     | 25a Centilor 1/X Centifying Physi  | cian: To the heat                     | Enjiy knowledna idear                 | h penumbel at the ris                         | na date and nines              | and duals the                    | ause(s) and marrier as          | stated  |
| 5                   | To the Hospital of within 24 hours at To the Funerei Di completely filled in  | Medical             | (Check out) 2 Medical Examine  | er: On the basis of<br>and manner sta | examination and/or in                 | vestigation, in my o                          | pinion, death occur            | red at the time, o               | date and place, and due         | to the cause(s)                                 |
| N                   | within 2<br>To the<br>complet   | Z.                  | 29b. Signature and title elecertifier  |                                       |                                       | 29c. Licens                                   | e number                       | 4                                | 29d. Date signed (Mont          | h, Day, Year)                                   |
|                     |   |                     | D ///  | )                                     |                                       | 158   | 3681                           |                                  | Juno                            | 28,2006   |
| Į,                  | et (  |                     | 30. Name and a idness of person who con  | apleted cause of de                   | eath (Item 23a) (Type,                |   |                                |                                  | 30.70                           | 3,2000  |
|                     |   |                     | Jude Alexander, M  | .D., 9901                             | Medical (                             | Center Dr                                     | ive, Rock                      | ville, N                         | 4D 20850                        |   |
|                     | St<br>Regist  | ate<br>rar          | 31. Date filed (Month, Day, Year)  JUN 3 0 20                                    | 32. Begistra                          | r's Signature                         | porte   |                                |                                  |                                 |   |
|                     |   |                     | /  | 1                                     |                                       |   |                                |                                  |                                 |   |

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

| James H. Mitchell  | State of Maryland  1- For State Registrar  | / Department of<br>Certificate of  |  | -   | g. No. 2001                          | 6 2263   |
|--|--|------------------------------------|--|---|--------------------------------------|--|
| Physician/<br>Medical Examiner   | Decedent's Name (First, Middle,Last)   | chell, Sr.                         |  | 2. Date of Death                            | h<br>Day Year                        | 3. Time of Death<br>0942 hrs                             |
|  | 4a. Facility Name (if not institution, give street and number)  Dorchester General Hospital  |                                    | 4b. City, Town, or Location<br>Cambridge                                       |   | 4c. County of Deat  Dorchester       | h  |
| Funeral<br>Director  |  | pe (In yrs. last birthday)  67 Yrs | Months Days Hours  |   | h(MM/DD/YYYY) 9. Bii<br>Forei        | rthplace (State or<br>gn<br>puntryMaryland               |
| any  | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Town or Locat           |  |   |                                      | 10d Inside City Limits                                   |
| ≥  | Maryland Dorchester  | Cambr:                             |  |   |                                      | 1 Yes 2 X No   |
| k S eath with the Maryland items 23a or 28a-f show ust be notified at once, inneral Director   | 10e. Street and Number<br>2905 Steamer Run Road  |                                    | 10f. Zip Code<br>21613   | 10  | g Citizen of What Cou<br>US          | intry?   |
|  | 11. Marital Status 1 Never Married 2 XX Married Armed Forces 1 X Yes 2 3 Widowed 4 Divorced or Dates:  | ? If Y                             | is Decedent of Hispanic Ori<br>es, specify Cuban, Mexicar<br>Yes 2 No specify. | n, Puerto Rican, etc.)                      | White, etc.                          | ican Indian, Black,                                      |
| O036 within 72 hours afl grene. her than "natural" Modical Examine ompleted by   | 15. Decedent's Education (Specify only highest grade cor<br>Elementary/Secondary (0-12) College (1-4 or  | 5+) 16a. Deceder<br>during m       | it's Usual Occupation (Give<br>ost of working life. DO NOT                     | kind of work done                           | 16b. Kind of Business/               |  |
| 5-003<br>led withir<br>tygiene.<br>other thi<br>the Medi   | 12<br>17. Father's Name (First, Middle, Last)  | Pos                                | stal Worker<br>  18.Mother   | r's Name (First, Middle, M                  | US Post                              | Office   |
| 2121;<br>Mental Fill<br>Marked<br>ceent, t   | Thomas Clifton Mitchell  19a. Informant's Name/Relationship (Type, Print)  | 19b. Mailing                       | Address (Street and Nur  | lary Stewart                                |                                      | e Zip Code)  |
| MD and 2 show afth and 2 show a 27 is raumatic   | Ada G. Mitchell Wife 20a Method of Disposition   | 2905                               | Steamer Run  |   |                                      | and 21613  |
| limore,<br>Pages I a<br>ment of He<br>tant: If ite   | 1 X Burial 2 Cremation 3 Removal from St 4 Diponation 5 Other Specify:   | crematory or other Greenlawn       | n Cemetery   | 06/29/06                                    |                                      | e, Maryland  |
| Ball<br>Permit<br>Import<br>injury   | 21. Sig/art re of Funeral Service Licensee  23. Fart I. Enter the disease, or complications that caused  | T                                  | Name and Address of Facility  Nomas Funeral  No Locust Str                     | Home, P.A.                                  | ge, Marylar                          | nd 21613<br>Approximate Interval                         |
| /Medical<br>Examiner   | failure. List only one cause on each line.   | Cardiovascular Dis                 |  |   |                                      | Between Onset and<br>Death                               |
| er.  | Sequentially list conditions, if any, leading to immediate b.  Due to (or as a cons  |                                    |  |   |                                      |  |
| mim  | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as e cons  |                                    |  |   |                                      |  |
| 0, s be executed sician and burial - transit   | d. UNPENDED AMENDED  | ·                                  |  |   |                                      |  |
| 68760, certificate be uning physicial seas the burnarian/Medi  | IF FEMALE: 23c. If yes, outcome and the second of the seco |                                    |  |   | 23d. Date of deliver                 | -  |
| Box 68760 he death certificate to the attending physicate for use as the bush sich system.   | past 12 months?  1   | time of                            | tal death 3Ectopi  | c pregnancy                                 | Month (                              | Day Year   |
| P.O. Bost that the destruction of detached for the by the best detached for the by the bost detached for the by by by by by by by by by by by by by  | Part II. Other significant conditions contributing to deat   | h but not resulting in the u       | underlying cause given in Pa   | l   | pacco use contribute to              |  |
| Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi cation: To Be Completed by Physician/Medical Es |  |                                    |  | 24a, Was an<br>autops<br>perform<br>1 Yes 2 | prior to oned? prior to oned?        | utopsy findings available completion of cause of es 2 No |
| /ital Rec<br>ysician: The<br>nis certificate<br>director, page   | 25. Was case referred to medical examiner? Hospital: 1 Inpatie   | ent 2 🗸 ER/Outpatient              | 26.Place of Death 3 DOA Other4   | 7   | Residence 6 Othe                     | r  |
| Sion of Vit<br>attending Physic<br>r death<br>ector: After this<br>by the funeral dir<br>cation: To I  | 27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury.  (Month, Day.)  | ury 28b. Time of I                 | 9[_]   | k? 28d. Describe ho                         | ow injury occurred                   |  |
| <u> </u>   | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)   | njury - At home, farm, stre        | et, factory, office building, e  | tc. 28f. Location (St<br>or Town, Sta       |                                      | ural Route Number, City                                  |
| D<br>To the Hospital<br>within 24 hours<br>To the Funcral<br>completely filled   | 29a. Certifier 1 Certifying Physician: To the best of mone) 2 Medical Examiner: The best of examiner stated.   |                                    | · ·  |   |                                      |  |
| 2  | 29b. Signature and title of certifier  |                                    | 29c, License number<br>O.C.M.E.  |   | 29d Date signed (Mo<br>June 30, 2006 | nth, Day, Year)  |
|  | <ol> <li>Name and address of person who completed cause of or<br/>David Fowler M.D. Chief Medical Exam</li> </ol>  | iner 111 Penn S                    | treet, Baltimore, MD   | 21201                                       |                                      |  |
| State<br>Registrar   | 31 Date filed (Month, Day, Year) 32. By distra   | ar's Signature                     | enfl)  |   |                                      |  |
| DHMH 17 Rev 1/2001   | 755  | ORIGINA                            | L  |   |                                      |  |

|                     |  |                 | State of Maryland / Depar  | tment of Health and M<br>ificate of Death  | lental Hygien                                       | 2000 27001   |
|---------------------|--|-----------------|--|--|---|--|
|                     |  |                 | Registrar  1. Decedent's Name (First, Middle, Last)  | nouto or Bouin   | 2. Date of Death                                    | 3. Time of Death   |
|                     | Physicia<br>/Medic   |                 | William Eugene Nibblett  |  | July 2  | 2006 4:15 P <sup>M</sup>   |
|                     | Examin   |                 |  | 4b. City, Town, or Location of Death   | 40  | c. County of Death   |
|                     |  |                 | Berlin Nursing & Rehabilitation Ctr.   | Berlin   |   | Worcester  |
|                     | Funeral<br>Director  |                 |  | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Year<br>June 28, 1 | 9. Birthplace (State or Foreign Country)  MD                         |
|                     |  |                 | Usual Residence of Decedent  |  | ourie 20, 1   | טויו ככפ   |
|                     | nyland<br>thow   |                 | 10a. State 10b. County 10c. City, Town or Loca   | tion   |   | 10d. Inside City Limits  |
|                     | 8a-f s   | Director        | MD Worcester Berlin  |  |   | 1 K Yes 2 □ No   |
|                     | with the   |                 | 9715 Healthway Dr.   | 10f. Zip Code<br>21811   |   | itizen of What Country?  |
|                     | na 23  | Funeral         |  | as Decedent of Hispanic Origin? (Spe<br>es, specify Cuban, Mexican, Puerto   |   | 14. Race - American Indian,  |
| 36                  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic evant, I'ra Madical Exertical initial to notified at once. | by Fun          | 1 Never Married 2 Married 1 Tyes 2 No  | /es, specify Cuban, Mexican, Puerto<br>□ Yes 2[X] No Specify:  | Rican, etc.)  | Black, White, etc.  Specify: White                                   |
| Maryland 21215-0036 | thour<br>sturai  | edt             | 15. Decedent's Education 16a. Deceder  | nt's Usual Occupation  |   | Kind of Business/Industry  |
| 215                 | hin 72   | Completed       | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kii iife. DC  | nd of work done during most of worki<br>ONOT use retired)  | ing   |  |
| 2                   | ed wit   | Con             | 9 Carpen   |  |   | uilding  |
| and                 | be fill<br>tal H<br>od oth   | Be              | 17. Father's Name (First, Middle, Last)  Marion Davis Nibblett   |  | e (First, Middle, Maide                             |  |
| ž                   | hould<br>d Mer<br>marke  | ဥ               |  | Address (Street and Number or Rura   | zabeth Tay  |  |
| Z<br>S              | od 2 s<br>Ith an<br>27 is r  |                 | 112  | Grays Corner Rd.   |   |  |
| ē,                  | s 1 ar<br>f Hea<br>item  |                 | 20a. Method of Disposition 20b. Place of Disposition   | tion (Name of Latery or other place)   | Date 20c. I   | Location - City or Town, State                                       |
| <u>E</u>            | Page<br>nent o<br>int: If<br>iry or  |                 | 1 □ Burial 2 □ Cremation 3 □ Hemoval from State  1 □ Donation 5 □ Other (Specify)  Cape Hen 10   | nen Crem. 7-3-20   | 006 Fra   | nkford, DE   |
| Baltimore,          | apartn<br>sports<br>ny inju  |                 | 21. Signature of Funery Service Licensee 22. I   | Name and Address of Facility The   | Burbage F   | uneral Home  |
| <u> </u>            | 6550   |                 |  | 08 William St., I  |   |  |
|                     |  |                 | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.   | the mode of dying, such as cardiac of  | or respiratory arrest,                              | Approximate Interval Between Qnset and Death                         |
|                     | Physician /Medical   |                 | Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  | todio resculu k  | JISCUE E  | Peers  |
|                     | Examiner   |                 |  |  |   |  |
|                     |  | Je              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):  |  |   |  |
|                     | nd<br>nd<br>transi   | Examiner        | Cause (Disease or injury that initiated events c   |  |   |  |
| 8760,               | death certificate be executed e attending physician and of for use as the burial-transit   | I Ex            | resulting in death) Last Due to (or as a consequence of):  |  |   |  |
| 87                  | physicate by the b   | dicai           | d  |  |   |  |
| 9 xc                | leath certific<br>attending p  | by Physician/Me | IF FEMALE: 23c. If yes, outcome of pregnancy   |  |   | 23d. Date of delivery  |
| . Box               | death<br>e atter   | clar            | in the past 12 months?  1 Vec. 3 Vec. 10 Vec.  | Ectopic pregnancy<br>Other (s <i>pecify</i> )  |   | Month Day Year   |
| P.O.                | t the<br>by th   | hys             | 9 ☐ Unknown  |  |   |  |
| Ś                   | es<br>be   |                 | Part II. Other significant conditions contributing to death but not resulting in the unc   | lerlying cause given in Part I.  | 23e. Did tobacco                                    | o use contribute to the cause of death?  2 No 3 Probably 4 Unknown   |
| Record              | > 0 0  | Completed       |  |  | 24a. Was an   | 24b. Were autopsy findings available prior to completion of cause of |
| Re                  | Ф <del>г</del> Б   | mo              |  |  | autopsy<br>performed?                               | prior to completion of cause of death?                               |
| Vital               | ician: Th<br>certificate<br>ector, pag   | BeC             | 25. Was case referred to medical examiner?   | 26, Place of Deat  | h (Check only one)                                  |  |
| of V                | d is   | 5               | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient   |  | me 5 Residence                                      |  |
| n c                 | te le  | Ö               | 27. Manner of Peath 1 Valural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury  | 28c. Injury at<br>Work?<br>M 1 ☐ Yes 2 ☐ No  | 28d. Describe how inj                               | ury occurred   |
| Division            | Attending r death.   | cat             | The content investigation  3 □ Suicide 6 □ Could not be determined and the could not be determined.  |  | 28f. Location (Street a                             | and Number or Rural Route Number,                                    |
| DΪ                  | ai or Attendir<br>s after death.<br>I Director: At<br>d in by the fu   | Certification;  | 4 Homicide determined building, etc. (Specify)   | The second of th | City or Town, Sta                                   |  |
|                     | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the   | edical          | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death of the |  |   |  |
|                     | To the within 2 To the complet   | Me              | 29b. Signature and title of coefficien   | 29c. License number  | 29d. D  | Date signed (Month, Day, Year)                                       |
|                     |  |                 | William ?  | D2876  | 9   | 113106   |
| 1                   | 2+1  |                 | 30. Name and address of person who completed cause of death (Item 23a) (Type, P  | 1209 Coces   | ted Hech  | Feneral Folial   |
|                     | St<br>Regist   | ate             | 31. Date filed (Month, Day, Year)  JUL 0 5 2006  32. Fegistrar's Signature   | and, s   |   | 1  |
|                     | riegisi  | 1161            | THE THE PARTY OF PART |  |   |  |

Nibblett, William

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JUNE 2006 4:40 PM **JERONE** Ε. NELSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F 70 Yrs. Director 577-50-5794 22 1935 WASHINGTON, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23e or 28e-f ahow the Medical Examiner must be notified at 1X Yes 2 □ No Director MD PRINCE GEORGE'S SPRINGDALE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20774 U.S.A. 3533 EDWARDS STREET 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No BLACK Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) COMMUNICATION ANALYST YRS GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be fi h and Mental H 7 Is marked otl UNKNOWN IDA NELSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 end 2 Department of Heelth ar Important: If Itam 27 la any Injury or othar trau 3533 EDWARDS STREET SPRINGDALE, MARYLAND 20774 ELVA NELSON/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) HARMONY CEMETERY 7/6/2006 LANDOVER, MARYLAND 21. Signature of Fameral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Systemy **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ed by the attending physicien and deteched for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. Il yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ۵ icate has been sign, page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 211100 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural Injury 5 Pending death. 1 ☐Yes 2 ☐No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Al within 24 hours after or To the Funeral Direc 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ditte of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature as D0055120 Mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) areme SE Such 310 Washing In DC 20032 falmer mD 1328 Southern 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar 0 32006

| 1 - Stata<br>Registrar   | State of M  | Maryland                      | •                                      | rtment of H   |                             | and M                  | -                                   | giene<br>Reg. No.          | 006                         | 22639  |
|--|---|-------------------------------|--|---|-----------------------------|------------------------|-------------------------------------|----------------------------|-----------------------------|--|
| 1. Decedent's Name (First, Middle, Las   | t)  |                               |  |   |                             |                        | 2. Date of De<br>Month              | ath<br>Day                 | Year                        | 3. Time of Death                                   |
| Physician ADELE P. NASSE   | 3   |                               |  |   |                             |                        | June 2                              |                            |                             | 1348 M   |
| Examiner 4a. Facility Name (If not institution, give   | street and number                                       | r)                            |  | 4b. City, Town, or  | r Location o                | of Death               |                                     | 4c. Co                     | unty of Death               | 1  |
| Suburban Hospi   |   |                               |  | Bethe   |                             |                        |                                     |                            | tgome                       |  |
| Funeral 5. Social Security Number 6. So  | 7. A  | Age (In yrs. las              | * .                                    | If Under 1 Year<br>Months Days                                | If Under<br>Hours           | 24 Hrs.<br>Min.        | 8. Date of Bir<br>(Month, Da        | y, Year)                   | 9. Birth                    | place (State or Foreign<br>untry)                  |
| Director 725-05-7388   |   | 84                            | Yrs.                                   |   | J                           |                        | Oct. 2                              | 7, 192                     | l Nev                       | w Jersey   |
| Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, 1                  | Town or Lo                             | cation  |                             |                        |                                     |                            |                             | 10d. Inside City Limits                            |
| A day  |   |                               | Alexa                                  | ndrio   |                             |                        |                                     |                            |                             | 1 Nes 2 No   |
| The street and Number  |   |                               | нтела                                  | 10f. Zip Code   |                             |                        | 1                                   | 10g. Citizen               | of What Cor                 | untry?   |
| 3492 Marta Cust  | a <b>c</b>  |                               |  | 22'   | 302                         |                        |                                     |                            | U.S.                        | ۸.   |
| 9 EE 11. Marital Status  | 12. Was Deceder<br>Armed Forces                         | nt Ever in U.S.               | 13. \                                  | Vas Decedent of H   |                             | gin? (Sp               | ecify Yes or No                     | )- 14.                     | Race - Amer<br>Black, White | ican Indian,                                       |
| 3492 Marta Cust.  11. Marital Status  1 □ Never Married 2 □ Married  3 ② Widowed 4 □ Divorced  | 1 XYes 2  |                               |  | Tes, specify Cube   | Specify:                    |                        | riloan, etc.,                       |                            |                             |  |
| S S S S S S S S S S S S S S S S S S S  | Year or Dates   | 5:                            |  |   |                             |                        |                                     |                            | , W                         | hite   |
| Complete Com |   |                               | 16a. Deced                             | lent's Usual Occup<br>kind of work done<br>OO NOT use retired | ation<br>during mos         | t of work              | ing                                 | 16b. Kind o                | of Business/I               | ndustry  |
| Elementary/Secondary (0-12)  | College (1-4o   | er 5+)                        |  | gistered  |                             |                        |                                     | нс                         | spita                       | 1  |
| N p 5 4 17. Father's Name (First, Middle, Last)  | 4   |                               | Ke                                     | gistered  |                             |                        | e (First, Middle                    |                            |                             | <u> </u>   |
| 17. Father's Name (First, Middle, Last)  Alfonse Padali  | 00  |                               |  |   |                             | Δd                     | elaide                              | Rarnar                     | d                           |  |
| Tath and Number 10a. State 10b. County Virginia 10a. State 10b. County Virginia 10b. Street and Number 3492 Marta Cust 11b. Marital Status 11b. Never Married 2 Married 3 Mediand 4 Divorced 15b. Decedent's Early Middle 5 Divorced 15b. Decedent's Early Middle 5 Divorced 15b. Decedent's Early Middle 5 Divorced 15b. Decedent's Early Middle 5 Divorced 15b. Decedent's Early Middle 5 Divorced 15b. Decedent's Early Middle 5 Divorced 15b. Decedent's Early Middle 5 Divorced 15b. Decedent's Early Middle 5 Divorced 15b. Decedent's Early Middle 5 Divorced 15b. Decedent's Early Middle 5 Divorced 15b. Decedent's Early Middle 5 Divorced 15b. Decedent's Early Middle 5 Divorced 15b. Decedent's Early Middle 5 Divorced 15b. Decedent's E |   |                               | 19b. Mailin                            | g Address (Street   | and Numbe                   |                        |                                     |                            |                             | ip Code)   |
| Julie Daberkow -   | Daughter  | Screen.                       | 6820                                   | Pineway   | , Uni                       | vers                   | ity Par                             | k, Mar                     | yland                       | 20782  |
| 20a. Method of Disposition   | D   | 20b. Plac                     | ce of Dispo                            | sition (Name of<br>natory or other place                      | ce)                         |                        | Date                                | 20c. Locati                | on - City or 1              | Town, State  |
| O S S S S S S S S S S S S S S S S S S S  |   | ιθ                            |  | ational Ce  | - 1                         | 07                     | /06/06                              | Tria                       | ngle,                       | Virginia   |
| Description of Principal Service United Baltima 27   10a. State   10b. County   10b. | \$00  |                               |  | . Name and Addre  |                             |                        |                                     |                            |                             |  |
| former that  |   | 1013                          |  |   |                             |                        |                                     |                            | ille,                       | MD 20781   |
| 23a. Part1. Enter the disease, or core shock, or heart failure. List only  | offications that caus<br>one cause on each              | ed the death.<br>line.        | Do not ent                             | er the mode of dyir   | ng, such as                 | cardiac                | or respiratory a                    | rrest,                     |                             | Approximate<br>Interval Between<br>Onset and Death |
| Immediate Cause (Final disease or condition  | a. Asr  | iratio                        | n Hyp                                  | охешіа  |                             |                        |                                     |                            |                             | 30 Minutes   |
| /Medical resulting in death) Examiner  |   | as a conseque                 |  |   |                             |                        |                                     |                            |                             |  |
| Sequentially list conditions   | b   | as a conseque                 | nce of):                               |   | _                           |                        |                                     |                            |                             |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | 20010 (01   | 20 4 001100420                | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |   |                             |                        |                                     |                            |                             |  |
| if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | Due to (or a  | as a conseque                 | ence of):                              |   |                             |                        |                                     |                            |                             |  |
| Sai sicie  | d.  |                               |  |   |                             |                        |                                     |                            |                             |  |
|  |   |                               |  |   |                             |                        |                                     | 1                          |                             |  |
| IF FEMALE: 23b. Was decedent pregnant  | 23c. If yes, outcom                                     | ne of pregnand                |  | Ectopic pregnancy   | v                           |                        |                                     | 23d                        | Date of deli                | •  |
| in the past 12 months?   |   | at time of dea                |  | Other (specify)   | ,                           | ···-                   |                                     |                            | Month                       | Day Year   |
| Physician: The law requires that the death certificate has been a sign ed to the death certificate has been as the death certificate has been  |   |                               | ting in the                            | adarbijas savjas av   | on in Part I                |                        | 23a Did I                           | tobacco uso                | contribute to               | the cause of death?                                |
| Part II. Other significant conditions of the part II. Other signif | •   | I DOL HOL 1950II              | uirg in the u                          | nderlying cadse giv   | /eniniralli                 |                        | -                                   | Yes 2KIN                   |                             | bably 4 Unknown                                    |
| Renal Insuffici  | ency  |                               |  |   |                             |                        | -                                   | -                          |                             |  |
| Anemia Sos Anemia  |   |                               |  |   |                             |                        | 24a. Was<br>auto                    |                            | prior to death?             | topsy findings available<br>completion of cause of |
| Vital Re Continue and Section The Section of Section 1 The Section of Section 1 The Section of Section 1 The Section of Section 1 The Section of Section 1 The Section of Section 1 The Section of Section 1 The Section of Section 1 The Section of Section 1 The Section of Section 1 The Section of Section 1 The Section of Section 1 The Sect |   |                               | _                                      |   |                             |                        | 1 ☐ Yes                             | - CO 100 -                 | 1 🗆 Yes                     | 2 No   |
| L Vital Victor of the control of th  | Hospital:   | atient 2 ⊟ El                 | D/Outpation                            | 2 DOA O#  |                             |                        | h <i>Check only</i><br>ome 5 ☐ Resi |                            | Other (Coa                  | n/4.1  |
| The state of the s | 28a. Date of in<br>(Month, I                            |                               | 28b. Time of                           |   |                             | arsing ric             | 28d. Describe                       |                            |                             | ,ny)   |
| A Vision   27. Maintel of Death   1 Section   1 Sectio |   | Day Year)                     | Injury                                 |   | nk?<br>]Yes 2□              | No                     |                                     |                            |                             |  |
| 27. Manner of Death    Continue  | 286. Place of   | Injury - At hometc. (Specify) | ne, farm, str                          | eet, factory, office  |                             |                        |                                     | Street and N<br>wn, State) | umber or Ru                 | ral Route Number,                                  |
| OSS Distriction of the last of | January,  |                               |  |   |                             |                        |                                     |                            |                             |  |
| DIVIS  SIND A STATE OF THE PROPERTY OF THE PRO | ysician: To the be<br>niner: On the basis<br>and manner | s of examination              | ledge, deat<br>on and/or in            | h occurred at the till<br>vestigation, in my o                | me, date ar<br>opinion, dea | nd place,<br>ath occur | and due to the<br>red at the time,  | date and pla               | d manner as<br>ice, and due | stated.<br>to the cause(s)                         |
| O D Signature and the of certifier 239. Signature and the of certifier 299.  | 00  |                               |  | 29c. Licens   | se number                   | , -, c                 | ,                                   | 29d. Date s                | igned (Monti                | n, Day, Year)                                      |
| 30. Name and address of person who   | completed cause of                                      | of death (Item 2              | 23a) (Type.                            |   | 56:                         | 3 / /                  |                                     | 06/                        | 16/20                       | W6   |
| 5454 Wisco   | ensin A   | 1ve                           | 5 mi 7                                 | re 104  | 0                           | Che                    | my Co                               | hase                       | , mo                        | 20815  |
| State 31. Date filed (Month, Day, Year)  Registrar JUL 0 3 2006  | completed cause of                                      | Strains Signatu               | April                                  | W   |                             |                        |                                     |                            |                             | -  |

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month JUN 27 2006 **Physician** MICHAEL PETER NEMCHICK 9:45 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 🖁 M 2 🗆 F 210-18-8168 Director 7/6/1927 78 Pennsylvania Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23s or 28s-1 show any injury or other traumatic event, the Madical Examinal must be nutilised at ODEs. Ft. Washington 1 ☐ Yes 2X No Maryland Prince George Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2715 Shawn Court USA 20744 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
NOTE: A sering the serior of t Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Admiral US Navy US Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Senick Nemchick ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2715 Shawn Ct. Ft. Washington, MD. 20744 Ethel M. Nemchick/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arl. Nat. Cemetery 9/5/06 Arlington, VA. 21. Signatus of Funeral Service 22. Name and Address of Facility Geo. P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician SEPSIS resulting in death) /Medical Due to (or as a consequence of): Examiner END STAGE LIVER DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). use as the burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Day 5 Other (specify) page 2 should be detached Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 XNO funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 XVatural 5 Pending М 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral D pelli 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06/28/2006 0101236795 (VA) pleted cause of death (Item 23a) (Type, Print) says NATIONAL NAVAL MEDICAL CENTER LINDSAY E. JONES MCUSN EETHESDA MD 20889-5600 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 3 2006 Registrar

|                        |  |                | 1 - For<br>State<br>Registrar  | State of M   | larylar             |                                   | artment of<br>rtificate o               |                                |                                  | Re                                | g. No                     | 06                                    | 226   | 41                   |
|------------------------|--|----------------|--|--|---------------------|-----------------------------------|---|--------------------------------|----------------------------------|-----------------------------------|---------------------------|---------------------------------------|---|----------------------|
| П                      | Physici  | an             | 1. Decedent's Name (First, Middle, Las   | •  |                     |                                   |   |                                |                                  | Date of Deat<br>Month             | Day                       | Year                                  | 3. Time of                                  |                      |
| 1                      | /Media   | al             | Marvin Gibbo:  4a. Facility Name (If not institution, give   |  |                     |                                   | 4b. City, Town                          | or Location                    |                                  | July 2                            | Ť                         | nty of Death                          | 11:50                                       | РМ                   |
|                        | Examin   | er             | Sligo Creek Nurs   |  |                     |                                   |   | koma F                         |                                  |                                   | 40.000                    |                                       | ntgomei                                     | rv                   |
| ~                      | Funeral  |                | 5. Social Security Number 6. Se  | 9x 7. A  |                     | last birthday)                    | If Under 1 Yes                          | ar If Under                    | 24 Hrs. 8.                       | Date of Birth<br>(Month, Day,     | Vaeri                     | 9. Birth                              | place (State o                              |                      |
| Ш                      | Director   |                | 579-07-9390  | <b>X</b> M 2□F   | 88                  | Yrs.                              | Months Day                              | S Hours                        |                                  | ril 3,                            |                           |                                       | hingtor                                     | ı, DC                |
|                        | and  |                | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. Ci             | ity, Town or Lo                   | ocation                                 |                                |                                  |                                   |                           | 1                                     | 10d. Inside Cit                             | tv Limits            |
|                        | Maryl<br>4 sho   | ro             | Maryland Monte   | gomery   | S                   | ilver S                           | Spring                                  |                                |                                  |                                   |                           |                                       | 1 🗆 Yes                                     |                      |
|                        | r 28a  | Directo        | 10e. Street and Number   | -  |                     |                                   | 10f. Zip Code                           | )                              |                                  | 10                                | Og. Citizen               | of What Cou                           | intry?                                      |                      |
|                        | th with  |                | 9204 Wendell Stre  | <u> </u>   |                     |                                   | 2090                                    | 1                              |                                  |                                   | US                        | : <b>A</b>                            |   |                      |
|                        | lams   | Funeral        | 11. Marital Status   | <ol> <li>Was Decedent</li> <li>Armed Forces</li> </ol>             | ?                   | J.S. 13.                          | Was Decedent of<br>If Yes, specify C    | f Hispanic Or<br>Jban, Mexical | igin? (Specify<br>n, Puerto Rica | Yes or No-<br>in, etc.)           | 14. F                     | Race - Amer<br>Black, White           |   |                      |
| 36                     | rs afte  | by Fi          | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced   | 1 <b>欠</b> Yes 2 □<br>If Yes, Give<br>Year or Dates:               |                     | 2 46                              | 1⊡Yes 2 <mark>1</mark> 20 N             | lo Specify:                    | :                                |                                   | Spe                       | cify:                                 |   |                      |
| 215-0036               | be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Itams 23a or 28a-f show event, tre M. dical Examiner coult be conflict at |                | 15. Decedent's Ed  | ucation  | 1942                | 16a. Dece                         | dent's Usual Occ                        |                                |                                  |                                   | 16b. Kind of              | Whi<br>Business/li                    |   |                      |
| 212                    | within 72<br>ene.<br>than "n   | plet           | (Specify only highest grade Elementary/Secondary (0-12)  | de completed) College (1-4or                                       | 5+)                 | (Give                             | kind of work doi<br>DO NOT use ret      | ne during mos<br>ired)         | st of working                    |                                   |                           |                                       | Printi                                      | ina                  |
| 7                      | filed wit<br>Hygiene<br>other the  | Completed      | 12   |  |                     | Fo                                | reman                                   |                                |                                  |                                   |                           | Engra:                                |   |                      |
|                        |  | Be             | 17. Father's Name (First, Middle, Last)  |  |                     |                                   |   | 18. Moth                       | er's Name (Fil                   | rst, Middle, N                    | Aaiden Surr               | name)                                 | J   |                      |
| <u>\S</u>              | 2 should be to and Mental is marked or raumatic eve  | ٤              | James Nalley  19a. Informant's Name/Relationship (7)   | ivea Print)  |                     | 10h Meili                         | na Address (Para                        |                                | lie Da                           |                                   | O'1                       | 04-4- 7                               | - 0-40                                      |                      |
| <u>a</u>               | d 2 sl<br>th an<br>th an<br>27 is r<br>traur   |                | Bernice L. Nalle   | •                            |                     | 1                                 | ng Address <i>(Stre</i><br>Wendell      |                                |                                  |                                   |                           |                                       |   |                      |
| ē,                     | t Health<br>tem 27   |                | 20a. Method of Disposition   | ,,   | 20b.                | Place of Dispo                    | sition (Name of matory or other p       | !                              | Date                             | - 2                               |                           | n - City or T                         |   |                      |
| Ë                      | Pages<br>nent of I   |                | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify  |  | 9                   | -                                 | ven Cemet                               | , ,                            | July<br>2006                     |                                   |                           | C                                     |   |                      |
| Baltimore, Maryland 21 | permit. Pages 1 and 2 should Department of Health and Men Important: # Item 27 is marke any injury or other traumatic once.  |                | 21. Signature of Funeral Service Licen   | S <del>00</del>  |                     | 22<br>Fr                          | 2. Name and Add                         | fress of Facili                |                                  | neral                             | Home                      | _Sprii                                | ng, Mar                                     | :yran                |
| m<br>—                 | 89 2 8 8   |                | I for help Liles   |  |                     | 50                                | 0 Unive                                 | rsity                          | Blvd,                            | W, Sil                            | ver S                     | pring.                                | , MD 20                                     | 901_                 |
|                        | Physician<br>/Medical<br>Examiner  | er             | 23a. P.M.f. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate. | one cause on each  | Myoca<br>s a consec | ardial<br>quence of):             | Infarct                                 |                                |                                  |                                   |                           |                                       | Approximate<br>Interval Betw<br>Onset and D | ween                 |
| 8/60,                  | icate be executed physician and the burial-transit   | dical Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | c. Due to (or as   | s a consec          | quence of):                       |   |                                |                                  |                                   |                           |                                       |   |                      |
| O. Box 6               | death certifi<br>e attending<br>id for use as  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome<br>1□Live birth<br>4□Pregnant a<br>9□ Unknown | 2 Feta              | aldeath 3□                        | Ectopic pregnar<br>Other (specify)      | ncy                            |                                  |                                   | 1                         | Date of deliv<br>Month                | •   | 'ear                 |
| ds, P                  | The law requires that the de<br>tie has been signed by the a<br>bage 2 should be detached f  | by             | Part II. Other significant conditions or   | ontributing to death   | but not res         | sulting in the u                  | nderlying cause                         | given in Part I                | l.                               |                                   | acco use co               |                                       | the cause of de                             |                      |
| Vital Records,         | The law require<br>ate has been sig<br>page 2 should b   | Completed      |  |  |                     |                                   |   |                                |                                  | 24a. Was an<br>autopsy<br>perform | ,                         | b. Were auto<br>prior to co<br>death? | opsy findings a<br>empletion of ca          | ivailable<br>luse of |
| g                      |  | e Co           | 25. Was case referred to medical   |  |                     |                                   |   | ne Place                       | e of Death (Ch                   |                                   | <b>X</b> No               | 1 🗌 Yes                               | 2 No  |                      |
|                        | Physician:<br>r this certifica<br>ral director, p  | 0 8            | examiner?  | Hospital:<br>1 ☐ Inpat   | ient 2              | ER/Outpatier                      | nt 3 DOA                                | )th or                         | ursing Home                      |                                   |                           | Other (Speci                          | (v)   |                      |
| Division of            | Attending Ph<br>death.<br>ctor: After th<br>y the funeral  | atlon: T       | 27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation   | 28a. Date of Inj<br>(Month, Da                                     | ury<br>ay Year)     | 28b. Time of<br>Injury            | W                                       |                                | 28d.                             | Describe ho                       |                           |                                       | ,,  |                      |
| DIVIS                  | or fifter  | Certification: | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of In<br>building, e                                    | jury - At h         | ome, farm, str                    | eet, factory, offic                     | 6                              |                                  | Location (Str<br>City or Town,    |                           | mber or Run                           | al Route Numb                               | Der,                 |
|                        | To the Hospital within 24 hours a To the Funeral I completely filled   | edical         | 29a. Certifier (Check only one) (Check only one)   | ysician: To the best<br>liner: On the basis<br>and manner s        | of examina          | owledge, deatl<br>ation and/or in | n occurred at the<br>vestigation, in my | time, date an<br>opinion, dea  | nd place, and a                  | due to the ca<br>t the time, da   | use(s) and<br>te and plac | manner as s<br>e, and due t           | stated.<br>o the cause(s)                   |                      |
|                        | To the To the Comp   | Ň              | 29b. Signature and title of certifier  | <i>T</i> ) -   | 0                   | <i>→</i>                          |   | nse number                     |                                  | 29                                | d. Date sig               | ned (Month,                           | Day, Year)                                  |                      |
|                        | 20+1   |                | 1/40   | NS.  | 576                 | 2                                 | D4                                      | 5471                           |                                  |                                   | Ju                        | ly 3,                                 | 2006  |                      |
| 4                      |  |                | 30. Name and address of person who o   | 1  | ·                   |                                   | · ·                                     | "                              |                                  |                                   |                           |                                       |   |                      |
|                        | - 01   |                | Yehesis Negussie,  | M.D.<br>32. ₽egist   |                     |                                   | Street                                  | , #214                         | , Silve                          | er Spr                            | ing,                      | MD 209                                | 910   |                      |
|                        | Sta<br>Registi   | - 4            |  | .006   | ر میر               | H. A                              |   |                                |                                  |                                   |                           |                                       |   |                      |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 5 State
Registra/AMFND#7+8pcrFH7/14/06, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Matilda 2006 1768 M Overton JUNE 24 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospilal Center YRINCE CHEVERLY Pence berges LOF-OTARES If Under 1 Year | If Under 24 Hrs. B. Date of Birth Jumbyh, Day, June 15 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1944 1 ☐ M 2X F 61 -62 Yrs. 241-62-8175 Tarboro, **Director** Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28e-f ehow the Medical Examiner must be notified at DC Washington None Director 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 820 48th Place NE 20019 United States Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 XNo Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "nu eny Injury or other traumatic event, the Medill once. Elementary/Secondary (0-12) College (1-4or 5+) 2 years Program Assistant Federal Government OPM18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Mary Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonny Overton (Daughter) 4014 Hamilton Street Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 7/3/06 Clinton, MD 21. Signature of Funeral Service 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street NW Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Arterioscherotic HEART DISEASE **Physician** Hypertensive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown рееп Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an hes autopsy rined? 2X No perfori certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 2 X ER/Outpatient 3 DOA 1 Inpatient this After the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Injury at Work? Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò within 24 hours a To the Hospital 1 Califying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 40055927 person who completed cause of death (Item 23a) (Type, Print) 3001

State

Registrar

31. Date filed (Month, Day, Year)

05

2006

32 Registrar's Signature

|                |  |                 | 1 - State<br>Registrar Amended#23p   |  | aryland/Dep<br>, KS 7/ <b>15/</b> e |   |                                |                                    | ene 2006               | 22643  |
|----------------|--|-----------------|--|--|-------------------------------------|---|--------------------------------|------------------------------------|------------------------|--|
|                |  |                 | 1. Decedent's Name (First, Middle, Last,   |  |                                     |   |                                | 2. Date of Death<br>Month          | Day Var-               | 3. Time of Death                                   |
| ı              | Physici<br>/Medic  |                 | BLAINE   | WARRE                                  | N OSTE                              | RLING                                       |                                | June                               | 28. 2006               | 4:15 A <sup>M</sup>                                |
| )              | Examin   |                 | 4a. Facility Name (If not institution, give  | street and number)                     |                                     |   | Location of Death              |                                    | 4c. County of Deat     |  |
|                |  |                 | Frederick Memor  | ial Hos                                | pital                               | Freder                                      | ick                            |                                    | Frederi                | ck   |
|                | Funeral  |                 | Social Security Number     6. Security Number  |  | (In yrs. last birthday              | If Under 1 Year<br>  Months Days            | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, ) | year) 9. Birt          | hplace (State or Foreign                           |
|                | Director   |                 | 339-07-6383  | ]M 2□F   8                             | 37 Yrs.                             | Working Days                                | 1                              | Jan. 27,1                          |                        | nois   |
|                | pu *   |                 | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, Town or L                | ocation                                     |                                |                                    |                        | 10d. Inside City Limits                            |
|                | aho  | 'n              | Maryland Frederic  | · k                                    | Frederi                             |   |                                |                                    |                        | 1 ☐ Yes 2 ☑ No                                     |
|                | 28a-f  | Directo         | 10e. Street and Number   | . K                                    | Trederi                             | 10f. Zip Code                               |                                | 100                                | g. Citizen of What Co  | **   |
|                | a or   |                 |  |  |                                     |   |                                | 100                                |                        | ountry :   |
|                | within 72 hours after death with the Maryland<br>ene.<br>then "neturel", or Items 23e or 28e-f ehow<br>the Medicel Exercit er must be notified at  | Funeral         | 7404 Willow Road   | 12. Was Decedent I                     | Ever in IIS 13                      | Was Decedent of Hi                          | ispanic Origin? (Sp            | acity Yes or No-                   | USA<br>14. Race - Ame  | rican Indian                                       |
|                | Iten d   | Ë               | 1 Never Married 2 Married  | Armed Forces?                          |                                     | If Yes, specify Cuba                        | n, Mexican, Puerto             | Rican, etc.)                       | Black, Whit            | e, etc.  |
| 36             | urs af   |                 | 3 ™ Widowed 4 □ Divorced   | If Yes, Give Year or Dates:            |                                     | 1 ☐ Yes 2 No                                | Specify:                       |                                    | Specify: Wh            | ite  |
| 21215-0036     | 2 hou  | Completed by    | 15. Decedent's Edu   |  | 16a. Dec                            | edent's Usual Occupa                        | ation                          | 16                                 | 6b. Kind of Business   | Industry   |
| 7              | nin 7.   | pie             | (Specify only highest grad<br>Elementary/Secondary (0-12)  | e completed) College (1-4or 5          | life                                | e kind of work done o<br>DO NOT use retired | during most of work:<br>()     | ing                                |                        | •  |
| 7              | d with   | E O             | Clementary/Secondary (0-12)  | 4                                      | 1                                   | il Engine                                   | er                             |                                    | Enginee                | rino   |
| פ              | othe<br>othe   | ВеС             | 17. Father's Name (First, Middle, Last)  |  |                                     |   | 18. Mother's Name              | (First, Middle, Ma                 |                        | 1.416  |
| <u>a</u>       | Aenta<br>Aenta<br>rked<br>tic a  | ToE             | Albin  | Ost                                    | erling                              |   | Ellen                          | H                                  | jorth                  |  |
| Maryland       | and N<br>a me  |                 | 19a. Informant's Name/Relationship (T)   | rpe, Print)                            | 19b. Mai                            | ing Address (Street a                       | and Number or Rura             | I Route Number, (                  | City or Town, State, 2 | Zip Code)  |
|                | and 2<br>alth a  |                 | Mark Osterling/Sor   | l .                                    | 274                                 | 6 Canada F                                  | Hill Road                      | , Myersvi                          | ille, MD 2             | 1733   |
| re             | of He<br>of He<br>item   |                 | 20a. Method of Disposition   |  | 20b. Place of Disp<br>cemetery, cri | osition (Name of<br>ematory or other plac   | e) [                           | Date 20                            | 0c. Location - City or | Town, State  |
| Ĕ              | Page<br>nent<br>int: if  |                 | 1 ☐ Burial 2 ☑ Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)   |  | Frederic                            | k Cremator                                  | y 6/29                         | /2006 Fr                           | rederick,              | MD   |
| Baltimore,     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avant, tra Mudical Exant at must be notified at Once. |                 | 21. Signature of Funeral Service Licens  | 90                                     |                                     |   |                                |                                    | neral Hom              |  |
| <b>m</b>       | 88 = 8   |                 | Hosumul  |  |                                     |   |                                |                                    | derick, MD             |  |
|                |  |                 | 23a. Part : Enter the disease, or composhock, or heart failure. List only o<br>Immediate Cause (Final  | ne cause on each lir                   | 10.                                 | nter the mode of dyin                       | g, such as cardiac o           | or respiratory arres               | st,                    | Approximate<br>Interval Between<br>Onset and Death |
| )              | Physician /Medical   |                 | disease or condition resulting in death)   | Trespire                               | a consequence of);                  | Hare Da                                     | CTO HS                         | mation                             | <b>1</b>               | + how yrs  |
|                | Examiner   |                 | AND THE PARTY OF T | Croc                                   |                                     | ion pneum                                   | onia                           |                                    |                        | Lhour  |
|                |  | er              | Sequentially list conditions if any, leading to immediate  | Due to (or as                          | a consequence of):                  |   |                                |                                    | 7                      | 10 GLAIS   |
|                | d<br>d<br>ansit  | Examiner        | cause. Enter Underlying Cause (Disease or injury that initiated events   | C. ch                                  | HICIL                               | calitis                                     |                                |                                    |                        | 4 days   |
| ó              | icate be executed<br>physician and<br>s the burial-transit   | Exa             | resulting in death) Last   | Due to (or as                          | a consequence of):                  |   |                                |                                    |                        | - 0  |
| 8760,          | sicie<br>ysicie<br>e bur   | dicai           |  | 1                                      |                                     |   |                                |                                    |                        |  |
| <b>68</b>      | ifficat<br>g phy<br>as th  | edi             |  |  |                                     |   |                                |                                    |                        |  |
| XO             | Attanding Physician: The law requires that the death certific rideath.  ector: After this certificate has been signed by the ettending by the funeral director, page 2 should be detached for use as   | by Physician/Me | IF FEMALE:<br>23b. Was decedent pregnant   | 3c. If yes, outcome                    |                                     | Oc  |                                |                                    | 23d. Date of del       | ivery  |
| .O. Box        | death<br>e ette<br>d for   | cla             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 4 Pregnant at                          |                                     | □Ectopic pregnancy<br>□ Other (specify)     |                                |                                    | Month                  | Day Year   |
| Ö              | t the<br>by th   | hys             | 9 □Unknown   | 9 Unknown                              |                                     |   |                                |                                    |                        |  |
| ۵.             | s tha  | y P             | Part II. Other significant conditions co.  |  |                                     | _   | en in Part I.                  | 23e. Did toba                      | icco use contribute to | the cause of death?                                |
| rd             | w require<br>been sig<br>should b  | b               | URINARY RET  | ention i-                              | ove to B                            | <b>CH</b>                                   |                                | 1 ☐ Yes                            | 2 □ No 3 □ Pr          | obably 4 Unknown                                   |
| Vital Records, | s bee  | Completed       | Peripheral 1   | JASEVIAN                               | Disna                               |   |                                | 24a. Was an                        |                        | itopsy findings available                          |
| æ              | The lav  | E               |  |  |                                     |   |                                | autopsy                            | ed? prior to death?    | completion of cause of                             |
| ta             | dcian: Th<br>certificate<br>ector, pag   | (D)             | 25. Was case referred to medical   |  |                                     |   | 26 Place of Deatl              | 1 ☐ Yes 25                         |                        | 2 No   |
| <u> </u>       | Physician: The this certificate har director, page   | 0.0             | examiner?  | lospital:                              | nt 2 ER/Outpatio                    | ent 3 DOA Othe                              | ar                             |                                    | ice 6 □Other (Spe      | cifu)  |
| 0              | g Phy<br>ter thi   | Ë               | 27. Manner of Death  | 28a. Date of Inju                      | ry 28b. Time                        | of 28c. Injury                              | at                             | 28d. Describe how                  |                        | city)  |
| Ö              | nding l<br>ath.<br>r: After<br>e funer   | atio            | 1 Avatural 5 ☐ Pending<br>2 ☐ Accident investigation   | (Month, Day                            | Year) Injury                        | World 1 □                                   | Yes 2 □No                      |                                    |                        |  |
| Division of    | Atte   | IIIC            | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined  | 28e. Place of Inju                     | ury - At home, farm, s              | treet, factory, office                      |                                |                                    | et and Number or Ru    | ural Route Number,                                 |
| Ō              | ator A<br>s after<br>i Direct  | Certification:  | 4 - Houseage   | building, etc                          | . (Specify)                         |   |                                | City or Town,                      | State/                 |  |
|                | ospit<br>hours<br>uners<br>y fille   |                 | 29a. Certifier 1 Certifying Phy  | sician: To the best                    | of my knowledge, dea                | th occurred at the time                     | ne, date and place,            | and due to the cau                 | use(s) and manner as   | stated.  |
|                | To the Hospital or Attentwith 24 hours after deatl To the Funeral Director: completely filled in by the  | Medical         | (Check only 2 Medical Exami  | ner: On the basis of<br>and manner sta | examination and/or ited.            | nvestigation, in my of                      | pinion, death occurr           | ed at the time, dat                | e and place, and due   | to the cause(s)                                    |
|                | To t<br>withi<br>To fi   | Σ               | 29b. Signature and title of certifier  | )                                      |                                     | 29c. License                                |                                | 290                                | d. Date signed (Mont   |  |
| )              |  |                 | > MARTHU At  | rem, 10                                |                                     | 04  | 16248                          |                                    | le /28/0               | Ç  |
|                |  |                 | 30. Name and address of person who c   | ompleted cause of d                    | eath (Item 23a) (Type               | o, Print)                                   | -1- 3/0-01                     | 701                                |                        |  |
| _              | 1  |                 | Martha J. Pierce   |  |                                     | , rrederi                                   | .ck, MD 21                     | . / U I                            |                        |  |
|                | Sta  | ite             | 31. Date filed (Month, Day, Year)  |  | 's Signature                        | 4   |                                |                                    |                        |  |

DHMH 17 Rev 1/2001

ORIGINAL

| •                              |   |                   | 1 - For<br>State<br>Registrar   | State of N  | /larylar                             |                                 |                         | nt of H                     |                             |                       | lental H                         | ygier<br>Reg. N        | 2000                                  | 226                                 | 544              |
|--------------------------------|---|-------------------|---|---|--------------------------------------|---------------------------------|-------------------------|-----------------------------|-----------------------------|-----------------------|----------------------------------|------------------------|---------------------------------------|-------------------------------------|------------------|
|                                |   |                   | 1. Decedent's Name (First, Middle, Last)  |   |                                      |                                 |                         |                             |                             |                       | 2. Date of I<br>Month            |                        | ay Year                               | 3. Time of                          | Death            |
|                                | Physici<br>/Medio   |                   | John William Obend  | erfer, J  | r.                                   |                                 |                         |                             |                             |                       | July                             |                        | 006                                   | 9:20                                | $\mathbf{P}^{M}$ |
|                                | Examin  |                   | 4a. Facility Name (If not institution, give   | street and numbe  | r)                                   |                                 | 4b. Cit                 | y, Town, or                 | Location of                 | of Death              |                                  | 4                      | c. County of Deat                     | h                                   |                  |
|                                |   |                   | Northampton Manor   |   |                                      |                                 |                         | deric                       |                             |                       |                                  |                        | rederick                              |                                     |                  |
|                                | Funeral   |                   | 5. Social Security Number 6. Sec  | 7.7<br>M 2□F  |                                      | last birthday)<br>Yrs.          |                         | er 1 Year<br>S Days         | If Under<br>Hours           | 24 Hrs.<br>Min.       | 8. Date of 8<br>(Month,          | Day, Yea               | 9. Birt                               | hplace (State of<br>untry)          | r Foreign        |
|                                | Director  |                   | 218-30-9880 Usual Residence of Decedent   |   | 89                                   | ) 115.                          | 1                       |                             | İ                           |                       | Dec.                             | 20,                    | 1916 Mar                              | yland                               |                  |
|                                | Mend we   |                   | 10a. State 10b. County  |   | 10c. Cit                             | ty, Town or Lo                  | ocation                 |                             |                             |                       |                                  |                        |                                       | 10d. Inside Cit                     | ty Limits        |
|                                | d eho   | ō                 | Maryland Frederick  |   | Fro                                  | derick                          |                         |                             |                             |                       |                                  |                        |                                       | 1 X Yes                             | 2 🗆 No           |
|                                | 158<br>280  | rec               | 10e. Street and Number  |   | 1116                                 | delick                          |                         | ip Code                     |                             |                       |                                  | 10g. (                 | Citizen of What Co                    | untry?                              |                  |
|                                | 3a o  |                   | 404 Wilson Place  |   |                                      |                                 | 21                      | 702                         |                             |                       |                                  | USA                    |                                       |                                     |                  |
|                                | death<br>ms 2   | Funeral Director  | 11. Marital Status  | 12. Was Deceder   |                                      | .S. 13.                         | Was Dec                 | edent of Hi                 | spanic Ori                  | gin? (Sp              | ecify Yes or I                   |                        | 14. Race - Ame                        |                                     |                  |
| 9                              | or its  | Ē                 | 1 ☐ Never Married 2 ☒ Married   | Armed Force   |                                      |                                 |                         |                             |                             |                       | Rican, etc.)                     |                        | Black, White                          | e, etc.                             |                  |
| 8                              | rai',   | d by              | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates   | : 1943-                              | -46                             | T Tes                   | 2 💢 No                      | Specify:                    |                       |                                  |                        | Specify: Whi                          | te                                  |                  |
| 5                              | within 72 hours after death with the Marylend<br>ene.<br>than 'natural', or itams 23a or 28e-f ehow<br>fra Madical Exertiner must be notilled at  | Completed         | 15. Decedent's Edu<br>(Specify only highest grad  | cation<br>e <i>completed)</i>   |                                      | (Give                           | kind of v               | ual Occupa                  | turina mosi                 | t of work             | ing                              | 16b.                   | Kind of Business/                     | Industry                            |                  |
| 21                             | athin a second  | ldu               | Elementary/Secondary (0-12)   | College (1-4o   | r 5+)                                | life.                           | DO NOT                  | use retired                 | )                           |                       |                                  |                        |                                       |                                     |                  |
| 2                              | tygien the true true true true true true true tru   |                   | 12<br>17. Father's Name (First, Middle, Last)   |   |                                      | Owner                           | /Ope                    | rator                       | 10 M-1b-                    | - N                   | /Fi 44id-                        |                        | rniture S                             | Store                               |                  |
| and<br>or                      | d of H  | Be                |   |   |                                      |                                 |                         |                             |                             |                       |                                  |                        | en Surname)                           |                                     |                  |
| <u>څ</u>                       | nark<br>naric   | 70                | John William Obendo   | m :   |                                      | 105 14-10                       |                         |                             |                             |                       | nche I                           |                        | T 0: 4                                |                                     |                  |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Importants if item 27 is marked other than 'natural', or itams 23a or 28e-f ehow appringury or other traumatic event, the Medical Examinat must be notified at ances.   | 8 8               | 19a. Informant's Name/Relationship (Ty  | ,   | wife                                 |                                 |                         |                             |                             |                       |                                  |                        | or Town, State, 2                     |                                     |                  |
| e,                             | 1 and<br>Healt<br>em 2<br>ther  |                   | Gladys Irene Denni:   | s_Obende  | 20b. F                               | Place of Dispo                  | sition (N               | ame of                      | 1                           |                       | erick,                           |                        | yland 2<br>Location - City or         | 1701<br>Town State                  |                  |
| ٥                              | ages<br>or or o   |                   | 1 X Burial 2 ☐ Cremation 3 ☐ F  | lemoval from Sta  | te G                                 | cemetery, cre                   | matory or               | other plac                  |                             |                       |                                  |                        |                                       |                                     |                  |
| 들                              | rtmer<br>rtent<br>njury   |                   | Signature of Funeral Service Licens   |   | Mt                                   | . 01iv                          | et Co                   | emete                       | ry 7                        | /12/                  | 2006                             | Fre                    | ederick,                              | Marylar                             | ıd               |
| Bal                            | Department of the post of the |                   | 21. Signature of Huneral Service Liberts  | <b>3</b>  | 3.50                                 | 2000                            | 2. Name                 | and Addres                  | s of Facilit                | <sup>y</sup> Kee      | ney ar                           | nd Ba                  | sford Fu                              | meral F                             | lone             |
|                                |   |                   | 23a. Part1 Enter the disease, or compl  | ications that caus  | MU(                                  | 0999 11                         | 06 Ea                   | ast C                       | hurch                       | Str                   | eet, I                           | rede                   | erick, M                              | 21701<br>Approximate                |                  |
|                                |   |                   | shock or heart lailure. List only of  | ne cause on each  | line.                                | n. Do not en                    | ter the mi              | ode or dynn                 | g, such as                  | cardiac               | or respiratory                   | arrest,                |                                       | Interval Bety<br>Onset and D        | ween             |
| 1                              | Physician /Medical  |                   | disease or condition resulting in death)  |   |                                      | Heart                           | Fail                    | ure                         |                             |                       |                                  |                        |                                       |                                     |                  |
|                                | Examiner  |                   |   | Due to (or a  |                                      |                                 |                         |                             | _                           |                       |                                  |                        |                                       |                                     |                  |
|                                |   | er                | Secuentially list conditions<br>if any, leading to immediate<br>cause. Enter Underlying<br>Cause (Disease or injury | Due to (or a  |                                      | structi                         | ve I                    | ung I                       | )isea:                      | se.                   |                                  |                        |                                       |                                     |                  |
| J                              | uted<br>d<br>ansit  | mlm               | cause. Enter Underlying Cause (Disease or injury that initiated events  |   |                                      |                                 |                         |                             |                             |                       |                                  |                        |                                       |                                     |                  |
| ٧<br>ت                         | exec<br>n and<br>ial-tra  | Examiner          | resulting in death) Last  | Due to (or a  | as a conseq                          | uence of):                      |                         |                             |                             |                       |                                  |                        |                                       |                                     |                  |
| 8760,                          | death ce'dificate be executed<br>e ettending physicien and<br>of for use as the burial-transit  | Physician/Medical |   | d   |                                      |                                 |                         |                             |                             |                       |                                  |                        |                                       |                                     |                  |
| 9                              | tifica<br>ng ph<br>as th  | led               |   |   |                                      |                                 |                         |                             |                             |                       |                                  | - 1                    |                                       |                                     |                  |
| Вох                            | eath certific<br>ettending pl   | Z.                | 23b. was decedent pregnant  | 3c. If yes, outcon<br>1 ☐ Live birth  |                                      |                                 | Tectonic                | pregnancy                   |                             |                       |                                  | 334                    | 23d. Date of deli                     | ,                                   |                  |
|                                |   | sicie             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4☐Pregnant<br>9☐Unknown   | at time of d                         |                                 | Other (                 |                             |                             |                       |                                  | - }                    | Month                                 | Day Y                               | 'ear             |
| P.O.                           | thet the de<br>ned by the e<br>detached t   | hy                | 9 Unknown   |   |                                      | 7.5                             |                         |                             |                             |                       |                                  |                        |                                       |                                     |                  |
|                                | láw requires thet the<br>es been signed by th<br>2 should be detache  | by                | Part II. Other significant conditions con   | ntributing to death   | but not res                          | ulting in the u                 | nderlying               | cause give                  | en in Part I.               |                       |                                  |                        | use contribute to                     |                                     |                  |
| D.C                            | w requires<br>been sign<br>should be  | Completed         | Hypertension  |   |                                      |                                 |                         |                             |                             |                       | 1[                               | Yes                    | 2∐No 3☐Pro                            | obably 4 🗆 U                        | nknown           |
| 9                              | hesbo   | ple               |   |   |                                      |                                 |                         |                             |                             |                       | 24a. Wt                          | as an<br>topsy         | 24b. Were au                          | topsy findings a<br>ompletion of ca | ivailable        |
| <u> </u>                       | The sete h  | Son               |   |   |                                      |                                 |                         |                             |                             |                       | pe<br>1 ☐ Yes                    | rformed?               | death?                                | 212 No                              |                  |
| /ita                           | Physician:<br>r this certific<br>ral director,  | Be                | 25. Was case referred to medical examiner?  |   |                                      |                                 |                         |                             | 26. Place                   | of Death              | (Check only                      | (one)                  |                                       |                                     |                  |
| 5                              | hysi<br>this c  | မ                 | 1 163 2 M   |   |                                      | ER/Outpatier                    |                         |                             | 4 LAI NU                    | rsing Ho              | me 5□Re                          | sidence                | 6 □Other (Spec                        | erfy)                               |                  |
| Ē                              | ing P   | iio               | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of Ir<br>(Month, L  | jury<br>Da <i>y Year)</i>            | 28b. Time o<br>Injury           |                         | 28c. Injury<br>Work         |                             |                       | 28d. Describ                     | e how in               | ury occurred                          |                                     |                  |
| sio                            | Attending r death. sctor: After by the fune   | cat               | 2 Accident investigation 3 Suicide 6 Could not be   |   |                                      |                                 | М                       |                             | res 2 □t                    |                       |                                  |                        |                                       |                                     |                  |
| Division of Vital Records,     | or At   | Certification:    | 4 Homicide determined   | 28e. Place of building,   | njury - At hi<br>etc. <i>(Specif</i> |                                 | reet, lacto             | ry, office                  |                             |                       | 281. Location<br>City or 7       | _(Street a<br>own, Sta | and Number or Ru<br>ite)              | ral Route Numb                      | 20 <i>r</i> ,    |
| _                              | pital<br>ours e<br>erai l   |                   | CO- C-different AM C-different  | 10 To |                                      |                                 |                         |                             |                             |                       |                                  |                        |                                       |                                     |                  |
|                                | To the Hospital or Attending Physician: The within 24 hours eiter death.  To the Funeral Director: After this certificete hy completely filled in by the funeral director, page   | edical            | 29a. Certifier 1 ☐ Certifying Phys<br>(Check only 2 ☐ Medical Exami   | nar: On the basis<br>and manner   | of examina                           | wiedge, deat<br>ition and/or in | h occurre<br>vestigatio | d at the tim<br>n, in my op | ie, date an<br>pinion, deal | d place,<br>th occurr | and due to the<br>ed at the time | ie cause(<br>e, date a | s) and manner as<br>nd place, and due | stated.<br>to the cause(s)          | )                |
|                                | To the<br>within<br>To the<br>comple  | Me                | 29b. Signature and title of certifier   |   | 318100.                              |                                 | 2                       | 9c. License                 | number                      | -                     |                                  | 29d. D                 | ate signed (Mont)                     | Dav. Year)                          |                  |
|                                | T With  |                   | 1   | mD.   |                                      |                                 |                         |                             |                             |                       |                                  |                        |                                       |                                     |                  |
| •                              | 10  |                   | 30. Name and address of person who co   | moleted esses   | death /lec-                          | n 23a\ /7:                      |                         | )54636                      | )                           |                       |                                  | July                   | 11, 200                               | b                                   |                  |
|                                | 10  |                   | Syed W. Haque, MD,  |   |                                      | ,                               | ,                       | Erec                        | lario                       | k M                   | arv1an                           | a o                    | 1701                                  |                                     |                  |
|                                | Sta   | te                | 31 Date filed (Month Day Year)  | 32 Degis  | strar's Signa                        |                                 | , w                     | 1.7.60                      | LLLL                        | الل وحد               | .гутан                           | <u>u Z</u>             | 1/71                                  |                                     |                  |
|                                | Registr   |                   | JUL 1 8 201   | JO CONT   | 1000                                 | G. A.                           | AL ASK                  | 2                           |                             |                       |                                  |                        |                                       |                                     |                  |

|                     |  |                | 1 - State of Maryland / Dep State of Maryland / Dep Ce   | artment of Health and M<br><i>rtificate of Death</i>   |                                    | ene 006                            | 22645   |
|---------------------|--|----------------|--|--|------------------------------------|------------------------------------|---|
|                     |  |                | 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month          | Day Year                           | 3. Time of Death                                |
|                     | Physici<br>/Medic  |                | Randall Wayne Parks  |  | July 2                             |                                    | 7:43 A <sup>M</sup>                             |
|                     | Examin   |                | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death   |                                    | 4c. County of Deal                 | h   |
|                     |  |                | Kline Hospice House  | Mount Airy  If Under 1 Year   If Under 24 Hrs.   | 0.0                                | Frederic                           |   |
|                     | Funeral Director   |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 215-50-8423 55 Yrs.  | Months Days Hours Min.   | 8. Date of Birth<br>(Month, Day, ) | (ear) 9. Birt                      | hplace (State or Foreign<br>buntry)             |
| Н                   |  | }              | Usual Residence of Decedent  |  | march ZZ,                          | 1951 Wasi                          | nington, D.C.                                   |
|                     | yland  |                | 10a. State 10b. County 10c. City, Town or L  | ocation  |                                    |                                    | 10d. Inside City Limits                         |
|                     | B Ma   | ctor           | Maryland Frederick Walker  | sville   |                                    |                                    | 1 ☐ Yes 2 ∏ No                                  |
|                     | or 28  | Director       | 10e. Street and Number   | 10f. Zip Code  | 109                                | g. Citizen of What Co              | ountry?   |
|                     | ath w  | ra             | 200 Chapel Court, #317   | 21793  |                                    | United S                           |   |
|                     | er de  | Funeral        | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  | Was Decedent of Hispanic Origin? (Spe<br>If Yes, specify Cuban, Mexican, Puerto I  | cify Yes or No-<br>Rican, etc.)    | 14. Race - Ame<br>Black, White     |   |
| 36                  | hours after death with the Maryland<br>tural', or Items 23e or 28e-f show<br>al Examinar must be notified at   | by F           | 11至Never Married 2 ☐ Married 1 ☐ Yes 2至No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:   | 1 ☐ Yes 2 ☑ No Specify:  |                                    | Specify: Whi                       | lte   |
| Ö                   | d within 72 hours after death with the Marylan<br>Hene.<br>I than "natural", or Items 23a or 28a-1 show<br>Itte Mudical Examinat must be notified at |                | 15 Decedent's Education 16a, Dece  | dent's Usual Occupation  | 16                                 | 6b. Kind of Business/              | Industry  |
| 215                 | within 72<br>ene.<br>then "na'   | ple            | (Specify only highest grade completed) (Give   | kind of work done during most of workii<br>DO NOT use retired)   | ng                                 |                                    | ŕ   |
| 21                  | al Hygiene. other than   | Completed      | 12 Cent  | ral Office Technic   | ian C                              | ommunicat                          | ions  |
| nd                  |  | Be (           | 17. Father's Name (First, Middle, Last)  | 18. Mother's Name  | (First, Middle, Ma                 | uiden Sumame)                      |   |
| yla                 | should be<br>nd Mental<br>marked o   | P              | James Nevelle Parks  | Sarah La   |                                    |                                    |   |
| Maryland 21215-0036 | ss 1 and 2 should E<br>of Health and Ment<br>item 27 is marked<br>r other treumatic e  |                |  | ng Address (Street and Number or Rura  |                                    |                                    | Zip Code)                                       |
| ത്                  | 1 and<br>1ealth<br>9m 27<br>ther t   |                | Jannis Snyder / Sister 1808  20a. Method of Disposition 20b. Place of Dispo  | Long Corner Rd., N   |                                    | MD 21771<br>oc. Location - City or | Tourn State                                     |
| Baltimore,          | ages<br>if it  |                | 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State  | matory or other place)   |                                    |                                    |   |
| 표                   | it. Partimer   |                |  | a Crematory  July 3<br>2. Name and Address of Facility   | , 2006 F                           | rederick,                          | Maryland  |
| Ba                  | permit. Pages i<br>Department of H<br>Important: If ite<br>any injury or ot<br>once.   | ga ga          | ▶ M  | esthaven Funeral So<br>501 Catoctin Mtn. 1   |                                    |                                    | <sup>ly</sup> 21701                             |
|                     |  |                | 23a. Part 1. Exter the diseast or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  | ter the mode of dying, such as cardiac o   | r respiratory arres                | t,                                 | Approximate<br>Interval Between                 |
|                     | Priysician   | 3 1            | Immediate Cause (Final disease or condition  | R METASTATIC   |                                    |                                    | Onset and Death                                 |
|                     | /Medical<br>Examiner   |                | resulting in death)  Due to (or as a consequence of):  |  |                                    |                                    |   |
|                     | 2  | <u>.</u>       | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):   |  |                                    |                                    |   |
|                     | led<br>Isit  | nlne           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  |  |                                    |                                    |   |
|                     | xecur<br>and<br>al-trai  | Examin         | that initiated events resulting in death) Last c   |  |                                    |                                    |   |
| 8760,               | cate be executed<br>physician and<br>the burial-transit  | dical          | L <sub>d</sub>   |  |                                    |                                    |   |
| 89                  | ificate<br>g phy<br>as the   | edic           | V  |  |                                    |                                    |   |
| Вох                 | The law requires that the death certific<br>te has been signed by the attending p<br>page 2 should be detached for use as                            | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3   | Ectopic pregnancy  |                                    | 23d. Date of deli                  | very  |
|                     | deatl  | slcla          | 1 Yes 2 No 4 Pregnant at time of death 5   | Other (specify)  |                                    | Month                              | Day Year  |
| P.0                 | that the de<br>led by the a<br>detached  | hys            | 9 🗆 ONKNOWN  |  |                                    |                                    |   |
|                     | es th<br>igned<br>be de  | by             | Part II. Other significant conditions contributing to death but not resulting in the u   | inderlying cause given in Part I.  |                                    | cco use contribute to              |   |
| ord                 | w requir<br>been si<br>should l  | ted            |  |  | 1 L Yes                            | 2 No 3 Pro                         | obably 4 QUnknown                               |
| Records,            | e law re<br>has be<br>je 2 sho   | ompleted       |  |  | 24a. Was an autopsy                | prior to d                         | topsy findings available completion of cause of |
| H                   | Ø <u>□</u>   | Con            |  |  | performe                           |                                    | 2 □ No  |
| Vital               | Physiclan:<br>this certific<br>ral director,   | Be             | 25. Was case referred to medical examiner?   | 26. Place of Death   |                                    |                                    | INPATIENT                                       |
| of                  | this aldir   | 은              | 1 Yes 2 No 1 Inpatient 2 ER/Outpatien  27. Manner of Death 28a. Date of Injury 28b. Time of  |  | ne 5 🗆 Residen                     | ce 6 K Other (Spec                 | city) HOSPICE                                   |
| OU                  | ding I<br>h.<br>After<br>funer   | tlon           | 1 Natural 5 Pending (Month, Day Year) Injury   | Work?  M 1 □ Yes 2 □ No  | od. Describe now                   | injury occurred                    |   |
| Division            | Attending or death. ector: After by the fune   | fica           | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st  |  | 8f. Location (Stre                 | et and Number or Ru                | ral Route Number.                               |
| D                   | after<br>Dire  | Certification: | 4 Homicide determined building, etc. (Specify)   |  | City or Town,                      | State)                             |   |
|                     | hours<br>hours<br>inera<br>y fille   |                | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deal   | h occurred at the time, date and place, a  | nd due to the cau                  | se(s) and manner as                | stated.   |
|                     | To the Hospital or Attendin<br>within 24 hours after death.<br>To the Funeral Director: Al<br>completely filled in by the fu                         | edical         | (Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.   | ivestigation, in my opinion, death occurre   | at the time, date                  | and place, and due                 | to the cause(s)                                 |
|                     | To the To the Comp   | Ž              | 29b. Signature and title of certifier  | 29c. License number  |                                    | . Date signed (Month               |   |
| )                   |  |                |  | 20056314   | J                                  | JLY 3, 200                         | 06  |
|                     | 7  |                | 30. Name and a ress of person who completed cause of death (Item 23a) (Type, BIND GEORGE 46 B THOMAS   | JOHNSON DRIVE  | FREDERIC                           | K MD 2                             | 1702  |
|                     | Sta<br>Registi   |                | 31. Date filed (Month, Day, Year)  JUL 0 5 2006 > 4  |  |                                    |                                    |   |
|                     |  |                | The same of the sa | A STATE OF THE STA |                                    |                                    |   |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Porter Louis Dalton 28, 12:51P 2006 June /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Ft. Washington Fort Washington Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**⊠**M 2□ F 87 Yrs. May 7,1919 Louisiana Director 437-09-8707 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pagas 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mantal Hygiene.
ant: If tem 27 is marked other then "naturel; or iteme 23a or 28a-f ehow ury or other theur and the notified any or other theur and the notified at any or other theur and the notified at 1 ☐ Yes 2 🖪 No Director Maryland Prince George's Oxon Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1012 Lindsay Rd. 20745 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status IXYes 2 No WWII 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Sign Painter 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gustav Porter Marie Dudoit ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catherine V. Porter - Wife 1012 Lindsay Rd., Oxon Hill, MD 20745 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition commutary, crommatory or other place) July 5,2006 Maryland Veterans Cem. permit. Pages Department of Importent: If II eny Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cheltenham, MD eral S 21. Signature of George P. Kalas Funeral Home, 6160 Oxon Hill Rd., Oxon Hill, P.A. Md 20745 Pant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) immediate Venticular Fibrillation Arrest Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law raquiras that the death cartificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. detached 9□ Unknown s bean signad by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records, Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypertension autopsy performed? 1 ☐ Yes 2 No Polymyalgia rheumatica cartificata or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2
☐ ER/Outpatient 3 ☐ DOA မ 1 ☐ Yes 2 🔯 No this within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Division 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 June 30, 2006 VA 0101058988 Kan, Mr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elizabeth Kau, MD 50 Irving St., NW Washington, DC 20422 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2906

|                     |  | _                   | For<br>State<br>Registrer  |  | laryland / D                           |                  | rtment of F  |                         |                           | ental H                     | Reg                             | ene<br>1. No?    | 06                                    | 226                                 | [47]                 |
|---------------------|--|---------------------|--|--|--|------------------|--|-------------------------|---------------------------|-----------------------------|---------------------------------|------------------|---------------------------------------|-------------------------------------|----------------------|
| - 5                 | Physici  | an .                | Decedent's Name (First, Middle, Last   |  |  |                  |  |                         |                           | Month July                  |                                 | Day 2006         | Year                                  | 3. Time of 7:00                     |                      |
|                     | /Medic   | al                  | Bonnie Jean Port  4a. Facility Name (If not institution, give  |  | ·)                                     |                  | 4b. City, Town, o  | r Location o            | of Death                  | July                        | 4,                              |                  | ty of Death                           | 7.00                                | A                    |
|                     | Examin   | ÇI                  | 7148 Lasting Light   |  | ,                                      |                  | Columbia   |                         |                           |                             |                                 | Howa             | rd                                    |                                     |                      |
|                     | Funeral<br>Director  |                     | 5. Social Security Number 6. Se  |  | ge (In yrs. last birti<br>49 \         |                  | If Under 1 Year<br>Months Days                             | If Under<br>Hours       | Min.                      | 8. Date of (Month,          | Day, Y                          | <sup>(ear)</sup> | Cou                                   | olace (State or<br>ntry)<br>ington, | _                    |
|                     | pu &   |                     | Usuat Residence of Decedent  10a. State 10b. County  |  | 10c. City, Town                        | or Lo            | cation   |                         |                           |                             |                                 |                  |                                       | 0d. Inside Cit                      | y Limits             |
|                     | faryla<br>sho  | ō                   |  |  | Columbi                                | 2                |  |                         |                           |                             |                                 |                  |                                       | 1 🗌 Yes                             | 2√ No                |
|                     | the 7  | rect                | Maryland Howard  10e. Street and Number  |  | COTUMDI                                | .a               | 10f. Zip Code  |                         |                           |                             | 100                             | g. Citizen o     | f What Cou                            | ntry?                               |                      |
|                     | 3a or  | Ö                   | 7148 Lasting Light   | Way  |  |                  | 21045  |                         |                           |                             | US                              | SA               |                                       |                                     |                      |
| 36                  | I within 72 hours after death with the Maryland<br>liene.<br>rthan "natural", or Items 23a or 28a-f show<br>the Medical Exama or must be molified at               | by Funeral Director | 11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  | 12. Was Deceden Armed Forces 1 Tyes 2 2 If Yes, Give Year or Dates | ?<br><b>L</b> No                       |                  | Was Decedent of H<br>f Yes, specify Cuba<br>1 ☐ Yes 2 🛣 No |                         | gin? (Spec<br>n, Puerto F | cify Yes or<br>Rican, etc.) | No-                             | ВІ               | ace - Americack, White,<br>ify: White | etc.                                |                      |
| 8                   | tural  | edt                 | 15. Decedent's Ed  | ucation  |  | Dece             | dent's Usual Occup   | ation                   |                           |                             | 16                              |                  | Business/In                           |                                     |                      |
| 215                 | in 72<br>in "na!<br>Wedic  | Completed           | (Specify only highest grade Elementary/Secondary (0-12)  | de completed) College (1-4o  | 5+)                                    | (Give            | kind of work done<br>DO NOT use retire                     | during mos.<br>d)       | t of workin               | ig                          |                                 |                  |                                       |                                     |                      |
| 212                 |  | E                   | 12   |  | Cus                                    | tor              | ner Servi  |                         |                           |                             |                                 | oofing           |                                       |                                     |                      |
| Maryland 21215-0036 | be filed<br>tal Hygi<br>d other<br>event.  | e                   | 17. Father's Name (First, Middle, Last)  |  |  |                  |  | 1                       |                           | (First, Mid<br>an La:       |                                 | aiden Suma<br>n  | ime)                                  |                                     |                      |
| yla                 |  | ၉                   | Roland Victor Baie   |  |  |                  | A 11 (O)   | L                       |                           |                             |                                 |                  | Otata 7                               | Code)                               |                      |
| Var                 | 12 sho<br>h and<br>7 is ma   |                     | 19a. Informant's Name/Relationship (7  |  |  |                  | ng Address (Street   |                         |                           |                             |                                 |                  |                                       |                                     |                      |
|                     | Pages 1 and 2 should<br>nent of Health and Mer<br>int: if Item 27 te marke<br>iry or other traumatic   |                     | Jeffrey A. Porterf 20a. Method of Disposition 1  Burial 2  Cremation 3  4  Donation 5  Other (Specify  | Removal from Stat  | 20b. Place of<br>cemeter               | Dispo<br>y, crei | Lasting sition (Name of matory or other pla                | ce)                     | D                         | ate                         | 20                              | Oc. Location     | - City or To                          | own, State                          | 0.0 a                |
| Baltimore,          | permit. Page<br>Department<br>Important: If<br>any injury or<br>once.  |                     | 21. Signature of Funeral Service Licen   |  | 4                                      | Ga               | ce Cremat<br>2 Name and Addre<br>Ding Home<br>Everly L     | ess of Facility<br>Crem | ation                     | a Ser                       | vic                             | e P.0            | O. Box                                | 784                                 |                      |
|                     | Physician<br>/Medical<br>Examiner  |                     | 23a. Part 1. Enter the disease, or compshock, or heart failure. List only of the disease or condition resulting in death)  Sequentially list conditions, | one cause on each<br>aMetastai                                     | ed the death. Do n                     | not ent          | er the mode of dyli  | ng, such as             | cardiac oi                | r respirator                | ry arres                        | st,              | 2227.342                              | Approximate Intervat Betwoen and E  | e<br>ween<br>Death   |
| 8760,               | ate be executed hysician and the burial-transit  | lical Examiner      | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                             | c  | is a consequence of                    |                  |  |                         |                           |                             |                                 |                  |                                       |                                     |                      |
| .O. Box 68          | The law requires that the death centificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown   |  | 2 Fetal death<br>at time of death      |                  | Ectopic pregnanc Other (specify)                           | у                       |                           |                             |                                 |                  | ate of deliv                          |                                     | /ear                 |
| Ф                   | uires that<br>n signed b   | þ                   | Part II. Other significant conditions of   | ontributing to death   | but not resulting in                   | n the u          | nderlying cause gr   | ven in Part I           | l.                        |                             | id toba                         | _                |                                       | he cause of d<br>pably 4 □L         |                      |
| Records,            | ystcian: The law requir<br>is certificate has been si<br>director, page 2 should   | Completed           |  |  |  |                  |  |                         |                           | a                           | Vas an<br>lutopsy<br>erformes 2 |                  | prior to co<br>death?                 | opsy findings amptetion of ca       | available<br>ause of |
| Vital               |  | BeC                 | 25. Was case referred to medical examiner?   |  |  |                  |  |                         |                           | (Check or                   |                                 |                  |                                       |                                     |                      |
| of V                | Physician:<br>this certific<br>ral director,   | 2                   | 1 ☐ Yes 2 X No   | Hospital: 1 ☐ Inpa   |  |                  |  | her: 4 N                |                           |                             |                                 |                  |                                       | fy)                                 |                      |
| u o                 | ding Phy<br>th.<br>After thi<br>tuneral  |                     | 27. Manner of Death 1 XNatural 5 ☐ Pending   | 28a. Date of Ir<br>(Month, L                                       | njury 28b. 1<br>Day Year) I            | Time o           | Wo   |                         |                           | 28d. Descri                 | ibe hov                         | v injury occ     | urred                                 |                                     |                      |
| Division            | or Attending<br>tter death.<br>lirector: After<br>n by the fune  | Certification;      | 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined   | e 28e. Place of  | Injury - At home, fa<br>etc. (Specify) | ırm, st          |  | Yes 2 🗌                 | -                         |                             | on (Stre<br>Town,               |                  | mber or Rur                           | al Route Num                        | ber,                 |
|                     | To the Hospital or Attendential within 24 hours after death To the Funeral Director: completely filled in by the   | edical Ce           |  | nysician: To the be<br>niner: On the basis<br>and manner           | of examination an                      |                  |  |                         |                           |                             |                                 |                  |                                       |                                     | )                    |
|                     | thin 2   | Med                 | 29b. Signatuse and title of certifier  | ()   | í /                                    |                  | 29c. Licen   | se number               |                           |                             | 29                              | d. Date sign     | ned (Month,                           | Day, Year)                          |                      |
|                     | F ≯ F 8  |                     | > Thub hach  | Kuda   | 1 X m                                  | LI)              | D385   | 509                     |                           |                             | J                               | uly 5            | , 200                                 | 5                                   |                      |
| 8                   | E.G  |                     | 30. Name and address of person who   | completed cause of   | 6                                      |                  | Print)   |                         |                           |                             |                                 | , _              |                                       |                                     |                      |
| O                   |  |                     | Nicholas W. Koutro   | elakos M.  | D. 1106                                | 5 L              | ittle Pat  | tuxent                  | Pkw                       | y. Co                       | 1um                             | bia,             | MD 21                                 | 044                                 |                      |
|                     | St   | ate                 | 31. Date filed (Month, Day, Year)  | 32. F gi   | strar's Signature                      |                  | locate a   |                         |                           |                             |                                 |                  |                                       |                                     |                      |
|                     | Regist   | trar                | JUL 6  | 2006   | euc s                                  | 1                |  |                         |                           |                             |                                 |                  |                                       | _                                   |                      |

# Baltimore, Maryland 21215-0036 76 In Imon, Patricia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 5 Patricia Ann Philmon 2006 1:50 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Atlantic General Hospital Berlin If Under 1 If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 ☐ M 2 ☐ XF Yre 63 Director 216**–**40–8360 3/2/1943 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 Is marked other than "neturel", or items 23e or 28e-f shov other treumatic event, the Medical Examinationst bust by radified at 1 ☐ Yes 257No Director Worcester Whaleyville 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number 21872 USA 7606 Old Ocean City Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver 12 Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katherine Reading James Maness 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an ant: If item 27 Is Peggy Greenwell (daughter) 7606 Old Ocean City Rd., Whaleyville, MD 21872 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State in ury or 7/7/06 Cape Henlopen Crem. 1 4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Euneral Service Licenses 108 William St., Berlin, MD 21811 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acute renal failure Physician /Medical Examiner nephropathu Sequentially list conditions, a.y., sacing to initial scause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 ☐ Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0056307

DHMH 17 Rev 1/2001

State

Registrar

me & Apo

J. van Egmond MD, Atlantic General Hospital, 9733 Healthway Dr., Berlin, MD 21811

30. Nameland address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month Day, Year)

|                            |  | -              | For 1_ State   | State of Marylan   | d / Depa                    | artme                            | nt of Health and N   | -                                     |                          | 0.06         | 22649  |
|----------------------------|--|----------------|--|--|-----------------------------|----------------------------------|--|---------------------------------------|--------------------------|--------------|--|
|                            |  |                | Registrar  |  | Cei                         | пітіса                           | te of Death  |                                       | g. No.                   | 000          |  |
|                            | Physicia<br>/Medic   | an             | 1. Decedent's Name (First, Middle, Last)  DOUGLAS P. PI                | ERREAULT   |                             |                                  |  | 2. Date of Death<br>Month<br>JULY 2,  | Day                      | Year         | 3. Time of Death  1:55 P <sup>M</sup>            |
| 1                          | Examin   |                | 4a. Facility Name (If not institution, give s                          | treet and number)  |                             | 4b. City                         | , Town, or Location of Death   |                                       | 4c. Cou                  | nty of Death | ١ .  |
|                            |  |                | SHADY GROVE ADVENT   | TIST HOSPITAL  |                             |                                  | CKVILLE  |                                       | MO                       | ONTGOM       |  |
|                            | Funeral<br>Director  |                | 5. Social Security Number 6. Sex 109-44-2213                           | 7. Age ( <i>in yr</i> s. 47  | last birthday)<br>Yrs.      | If Unde<br>Months                | or 1 Year If Under 24 Hrs. Days Hours Min.                                   | 8. Date of Birth (Month, Day, MAY 18, | Year)<br>1959            | 9. Birth     | nplace (State or Foreign<br>untry)<br>VT         |
|                            | deeth with the Maryland<br>me 23a or 28a-f ehow<br>Finust be notified at   | ō              | Usual Residence of Decedent  10a. State 10b. County  MARYLAND MONTGON  |  | y, Town or Lo               | ocation                          | GAITHERSBURG   |                                       |                          |              | 10d. Inside City Limits 1 Yes 2 No               |
| 3                          | or 28a-  | Director       | 10e. Street and Number   | DDIVE  |                             | 10f. Z                           | ip Code  | 10                                    | g. Citizen               | of What Co   |  |
| -                          | 236  | ra             | 119 CANFIELD HILL  | DKIVE<br>2. Was Decedent Ever in U.  | C 12                        | Was Doo                          | 20878  | acity Ves or No-                      | 14 5                     | U.S.A        | ncan Indian,                                     |
|                            | n /2 nours aner deem with the marylan<br>"naturel", or lleme 23a or 28a-1 ehow<br>adical Examinar must be incliffed at   | by Funerai     | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced    | Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:                       | 1                           |                                  | edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto<br>2 X No Specify: | Rican, etc.)                          |                          | Black, White |  |
| o i                        | in 72 hou<br>n "nature<br>ledical E  | Completed      | 15. Decedent's Edu<br>(Specify only highest grade                      | completed)   | 16a. Dece<br>(Give<br>life. | dent's Us<br>kind of w<br>DO NOT | ual Occupation<br>rork done during most of work<br>use retired)              | king                                  | 16b. Kind o              | f Business/I | industry   |
| 7                          | within<br>ene.<br>then "   | E              | Elementary/Secondary (0-12)  | College (1-4or 5+)   | F                           | INAN                             | CIAL ANALYST   | (                                     | OVER                     | NMENT        | CONTRACTING                                      |
|                            | be filed<br>htal Hygid<br>od other<br>event, I   | Ö              | 17. Father's Name (First, Middle, Last)                                |  |                             |                                  |  | ne (First, Middle, M                  |                          |              |  |
| ⊆ .                        | d be<br>ental<br>ked c   | To B           | RICHARD PERREAULT  |  |                             |                                  | MARCELLE   | DESMARA                               | S                        |              |  |
| <u> </u>                   | should to<br>nd Ment<br>marked<br>umatic   | F              | 19a. Informant's Name/Relationship (Ty                                 | oe, Print)   | 19b. Maili                  | ng Addre                         | ss (Street and Number or Ru  | ral Route Number,                     | City or To               | wn, State, Z | (ip Code)  |
| <u>8</u>                   | od 2<br>1th ar<br>27 le  |                | ELLEN G. PERREAUL  | r/WIFE   | 119                         | CANF                             | IELD HILL DRV  | IE, GAITH                             | IERSBI                   | URG, M       | ID 20878   |
| മ്                         | t Hear<br>Hear<br>Hear<br>Hear<br>Othe   |                | 20a. Method of Disposition   |  | Place of Disponentery, cre- | osition (N                       | ame of other place)  | Date 2                                | 20c. Location            | on - City or | Town, State                                      |
| Ê.                         | e e e e e e e e e e e e e e e e e e e  |                | 1 ☑ Burial 2 ☐ Cremation 3 ☐ P<br>4 ☐ Donation 5 ☐ Other (Specify)     | emoval from State  | •                           | -                                | MEMBRANCE 07/  | 06/2006                               | CLARS                    | SBURG.       | MARYLAND   |
| Baltimore,                 | permit. Pages 1 and 2 should Deperment of Heath and Mer Important: If Item 27 Is marke eny injury or other traumatic   |                | 21. Signature of Funeral Borvice License                               |  | $\mathbf{D}^{2}$            | 2. Name<br>ANZA                  | and Address of Facility<br>NSKY-GOLDBERG<br>ROCKVILLE PIK                    | MEMORIAI                              | CHAI                     | PELS,        | INC.   |
|                            |  |                | 23a. Part1. Enter the disease, or compl                                | cations that caused the deat   |                             |                                  |  |                                       |                          |              | Approximate<br>Interval Between                  |
| <b>A</b>                   | Thursinian.  |                | shock, or heart failure. List only or<br>Immediate Cause (Final        | A Ao C   | Nicol                       | Lut                              | 1-1-19   |                                       |                          |              | Onset and Death                                  |
|                            | Physician<br>/Medical  |                | disease or condition resulting in death)                               | Due to (or as a conseq   | luence of):                 | 771                              | MACT   |                                       |                          |              | 3003/100   |
|                            | Examiner   |                |  |  | ,                           |                                  |  |                                       |                          |              |  |
|                            | ۹  | e              | Sequentially list conditions, if any, leading to immediate             | bue to (or as a conseq   | uence of).                  |                                  |  |                                       |                          |              |  |
|                            | uted<br>ansit  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events |  |                             |                                  |  |                                       |                          |              |  |
| ~                          | be executed<br>ician and<br>burial-transit   | Exa            | resulting in death) Last   | Due to (or as a conseq   | uence of):                  |                                  |  |                                       |                          |              |  |
|                            | a () -   | ia             |  | 1  |                             |                                  |  |                                       |                          |              |  |
| 89                         | death certificate<br>e attending physi<br>d for use as the I   | an/Medic       |  |  |                             |                                  |  |                                       | 1                        |              |  |
| Вох                        | nding<br>use   | S              | IF FEMALE:<br>23b. Was decedent pregnant                               | 3c. If yes, outcome of pregna  | ancy                        | Testonio                         | pregnancy  |                                       | 23d.                     | Date of del  |  |
| m                          | death<br>e atte<br>d for   | ਹ              | in the past 12 months?<br>1 ☐ Yes 2 Ø No                               | 1 Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of c                             |                             | Other (                          |  |                                       |                          | Month        | Day Year   |
| 0.                         | at the de<br>by the a<br>tached  | Physi          | 9 ☐ Unknown  | 9□ Unknown   |                             |                                  |  |                                       |                          |              |  |
|                            | es tha<br>gned<br>be de  | b              | Part II. Other significant conditions con                              | ntributing to death but not res  | sulting in the u            | underlying                       | cause given in Part I.   |                                       | accouse o                |              | othe cause of death?                             |
| Ö                          | w requir<br>been si<br>should  | Completed      |  |  |                             |                                  |  | 24a. Was a                            | 1 24                     | 4b. Were au  | itopsy findings available completion of cause of |
| æ                          | helan<br>e has<br>ge 2   | E G            |  |  |                             |                                  |  | autops                                | ned?                     | death?       |  |
| a                          | ician: Th<br>certificete<br>rector, pag  |                | 25. Was case referred to medical                                       |  |                             |                                  | 26 Place of Day  | th (Check only on                     |                          | 1 L Yes      | 2 □ No   |
| ⋚                          | sicie<br>cert  | o Be           | examiner?  | lospital:  | ER/Outpatie                 | ent 3□ l                         | Other  | ome 5□Reside                          |                          | Other (Sne   | cutu)  |
| ō                          | Phy<br>r this<br>aral di   | 5. To          | 27. Manner Death   | 28a. Date of Injury  | 28b. Time o                 |                                  | 28c. Injury at   | 28d. Describe ho                      |                          |              | Sily)  |
| O                          | ding th.   | ţ              | Natural 5 Pending 2 Accident investigation                             | (Month, Day Year)  | Injury                      | М                                | Work?<br>1 ☐ Yes 2 ☐ No  |                                       |                          |              |  |
| Division of Vital Records, | after dea<br>Director<br>In by the   | Certification: | 3 Suicide 6 Could not be<br>4 Homicide determined                      | 28e. Place of Injury - At h<br>building, etc. (Speci                           |                             | treet, fact                      | ory, office  | 28f. Location (St<br>City or Town     | reet and N<br>n, State)  | umber or Ru  | ıral Roule Number,                               |
|                            | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificete h completely filled in by the funeral director, page | Medicai C      |  | sician: To the best of my known of the basis of examinating and manner stated. |                             |                                  |  |                                       |                          |              |  |
|                            | o the  | ₹              | 29b. Signature and title of certifier                                  |  |                             | 2                                | 9c. License number   | 2                                     | 9d. Date <sub>r</sub> si | gned (Mont   | h, Day, Year)                                    |
|                            | 13/  |                | Vac  |  |                             |                                  | 038847   | 3                                     | 27/                      | 02/          | 6  |
| •                          | 1  |                | 30. Name and address of person who co                                  | ompleted cause of death (Ite   | m 23a) (Tune                |                                  | V . 0 0 1 1  |                                       | 7 1                      | - 1          | , , ,  |
|                            |  |                | DR. DAVID KLEIN,   |  |                             |                                  | ROCKVILLE, M   | ARYLAND                               | 20850                    | )            |  |
| 80                         | St   | ate            | 31. Date filed (Month, Day, Year)                                      | 32. Registrar's Sign   | atura                       | book                             |  |                                       |                          |              |  |
|                            | Regist   |                | JUL 05 2   | 006  | 15 A                        |                                  |  |                                       |                          |              |  |

| K                                   | cor   | 16                | Lement Flease   | Type of Print in Blac   |                            |  |  | _                             |                                     |
|-------------------------------------|---|-------------------|---|---|----------------------------|--|--|-------------------------------|-------------------------------------|
|                                     | `   | 4                 | For<br>State<br>Registrar   | State of Maryland / I   | •                          |  | vientai Hygien                             | e                             | 00000                               |
|                                     |   |                   | Registrar   |   | Certificat                 | e of Death   | Reg. N                                     | 10/11/0                       | 22650                               |
|                                     | pi  |                   | Decedent's Name (First, Middle, La  | 0   | 1.                         |  | 2. Date of Death Month                     | ay Year                       | 3. Time of Death                    |
|                                     | Physicia<br>/Medic  |                   | Erma  | lean PUT  | Nell                       |  | 06 10                                      | 06                            | D:300 AM                            |
|                                     | Examin  |                   | 4a. Facility Name (If not institution, giv  | e street and number)  | 4b. City,                  | Town, or Location of Death                               | 4  | c. County of Death            | 4                                   |
|                                     |   |                   | 1537 SNAW   | Hill Koad   | 15.4                       | ockton   | 1  | Dorces                        | ter                                 |
|                                     | Funeral   |                   | 5. Social Security Number 6. S  |   | irthday) If Unde<br>Months | 1 Year If Under 24 Hrs.<br>Days Hours Min.               | 8. Date of Birth<br>(Month, Day, Yea       | 9. Birthpla                   | ace (State or Foreign               |
|                                     | Director  |                   | 455-56-1102   | □M 2XF 70   | Yrs.                       | Days Hours IIII.   | 1/-23-3                                    | 5                             | TX                                  |
|                                     | Ð   |                   | Usual Residence of Decedent   |   |                            |  |  |                               |                                     |
|                                     | how   | ,                 | 10a. State 10b. County  | 10c. City, Tov  | vn or Location             |  |  | 10                            | d. Inside City Limits               |
|                                     | Ma-fs   | 흕                 | M.d. Worce  | ster Stoc   | Kton                       |  |  |                               | 1 Yes 2 □ No                        |
|                                     | 7.28  | ire               | 10e. Street and Number  | 11. 20 1  | 10f. Zip                   | Code   | 10g. C                                     | itizen of What Count          | ry?                                 |
|                                     | death with the Maryland ms 23e or 28a-f show  | Funeral Director  | 1577 SNOW   | Hill Kond   |                            | 21864  |  | U.J. A                        | ,                                   |
|                                     | death<br>ms 2   | Jera              | 11. Marital Status  | 12. Was Decedent Ever in U.S.                                   | 13. Was Dece               | dent of Hispanic Origin? (Spirify Cuban, Mexican, Puerto | pecify Yes or No-                          | 14. Race - America            |                                     |
| 0                                   | after r. Ite  |                   | 1 ☐ Never Married 2 ☑ Married   | Armed Forces? 1 ☐ Yes 2 No If Yes, Give                         |                            |  | J Filoan, etc.)                            | Black, White, e               | nc.                                 |
| 3                                   | ol', o  | b                 | 3 ☐ Widowed 4 ☐ Divorced  | Year or Dates:  | 1 ☐ Yes                    | 2 No Specify:  |  | Specify: R/C                  | ck                                  |
| 5-0036                              | filed within 72 hours after death with the Marylan Hygene. Hygene the West State of Show ther then "naturel", or litems 23e or 28a-f show ent, It is Medical Exertical must be notified at  | Completed         | 15. Decedent's E  | ducation 16a  | a. Decedent's Usu          | al Occupation<br>ork done during most of wor             | 16b.                                       | Kind of Business/Ind          | ustry                               |
| 2                                   |   | pie               | (Specify only highest gra<br>Elementary/Secondary (0-12)  | College (1-4or 5+)  | lite. DO NOT               | se retired)  | A A  | 1                             |                                     |
| 7                                   | d with  | E                 | 12+6  | 5   | 40cmui                     | 50-  | Co   | mphell                        | Soun                                |
| ᅙ                                   | be filed within 72 ho<br>tal Hygiene.<br>d other then "natu<br>event, if e Me Jical   | Be C              | 17. Father's Name (First, Middle, Last  |   | 1                          | 18. Mother's Nan   | ne (First, Middle, Maide                   | en Sumame)                    |                                     |
| <u>a</u>                            |   | ToB               | John Edwa   | and Love.   |                            | 010  | R. Mi                                      | 1.ton                         |                                     |
| Maryland                            | ges 1 and 2 should to the the and Men If item 27 is marke or other traumatic  |                   | 19a. Informant's Name/Relationship (  | Type, Print) 19   | b. Mailing Address         | (Street and Number or Ru                                 | ral Route Number, City                     | or Town, State, Zip           | Code)                               |
| Š                                   | and 2 sealth ar n 27 is   |                   | Janac Duraci  | 5- Churchad 13  | 527 50                     | Day Hill Ro  | 1. Stock                                   | 4 And                         | 2186k                               |
| ō,                                  | s 1 and of Health item 27 other tr  |                   | 20a. Method of Disposition  | 20b. Place o  | of Disposition (Na         | me of  | Date 20c.                                  | Location - City or Tox        | wn, State                           |
| altimore,                           | Pages<br>nent of<br>int: If it  |                   | 1 ABurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Speci  | Hemoval from State  | ery, crematory or          | 1 ( 6-11   | 106 51                                     | ackla .                       | md                                  |
| ≣                                   |   |                   | 21. Signature of Funeral Service Lice   | 1/10/40   | 22. Name a                 | nd Address of Facility Ro                                | 1-00 37                                    | OCK FON                       | 111-                                |
| Ba                                  | permit. Pag<br>Department<br>Importent:<br>eny injury o   |                   |   | 70  | 000                        | 1 7 10   | onic sm                                    | TUTONO                        | 210-                                |
|                                     |   |                   | 23a Part 1 Entert a disease of con  | plications that caused the death. Do                            | not enter the mo           |  | on OCC (                                   | Fty, Mai                      | Approximate                         |
| Н                                   |   |                   | 23a. Part 1. Enter the disease, or comshock, or heart failure. List only  |   |                            |  |  |                               | Interval Between<br>Onset and Death |
|                                     | Physician   |                   | Immediate Cause (Final disease or condition resulting in death)   | a. Chacuic Ubs  | tructiv                    | - Polonouse  | y Discuse                                  |                               | 6 worths                            |
| г                                   | /Medical<br>Examiner  |                   | <b>1</b>  | Due to (or as a consequence                                     | e of):                     |  | /  |                               |                                     |
| н                                   |   | _                 | Sequentially list conditions,   | b. Due to (or as a consequence                                  | a of):                     |  |  |                               |                                     |
|                                     | e sit   | Examiner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a consequence                                     | 017.                       |  |  |                               |                                     |
|                                     | and<br>I-tran   | кап               | that initiated events<br>resulting in death) Last   | c   | of):                       |  |  |                               |                                     |
| ,60,                                | te be executed<br>ysician and<br>e burial-transit   |                   |   | 545 15 (51 45 4 511154451115                                    |                            |  |  |                               |                                     |
| _                                   | 2 > 4   | dicai             | •   | d   |                            |  |  |                               |                                     |
| x 68                                | leath certific:<br>attending pl   | Me                | IF FEMALE:  | Office Maria automora of programme                              |                            |  |  |                               |                                     |
| Ô                                   | ath c<br>ttend<br>or us   | an                | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat |                            |  |  | 23d. Date of deliver<br>Month | ry<br>Day Year                      |
| <u>.</u>                            | e de<br>the a   | sic               | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4□Pregnant at time of death<br>9□Unknown                        | 5 Other (s                 | pecify)  | -  |                               |                                     |
| Division of Vital Records, P.O. Box | res that the de<br>signed by the a<br>l be detached f   | by Physician/Medi | Part II. Other significant conditions   |   | in the warderheims         | naves gives in Boot I                                    | 23e Did tobacc                             | use contribute to the         | a cause of death?                   |
| Ś                                   | es the  |                   |   | Dise is   | in the underlying          | Cause given in Fait i.                                   |  | 2 □ No 3 □ Proba              |                                     |
| ord                                 | w require<br>been si<br>should I  | Completed         | 0/2011/1  | 27JE4J&   |                            |  | 12 165                                     | 2 140 3 100                   |                                     |
| 00                                  | as be   | pie               |   |   |                            |  | 24a. Was an autopsy                        | prior to con                  | sy findings available               |
| Œ.                                  | The<br>ate h  | ПО                |   |   |                            |  | performed?                                 | death?                        | 2□ No                               |
| ita                                 | sicien: The law<br>certificate has b<br>irector, page 2 s   | Be C              | 25. Was case referred to medical  |   |                            | 26. Place of Dea   | th (Check only one)                        |                               |                                     |
| 2                                   | ysici<br>is cei<br>direc  | To B              | examiner?<br>1 ☐ Yes 2 ② No   | Hospital: 1 ☐ Inpatient 2 ☐ ER/C                                | Outpatient 3 D             | OA Other: 4 Nursing H                                    | lome 5 Residence                           | 6 ☐Other (Specify             | )                                   |
| 0                                   | g Ph<br>er th<br>eral   | <u></u>           | 27. Manner of Death   |   | Time of Injury             | 28c. Injury at<br>Work?                                  | 28d. Describe how in                       |                               |                                     |
| o                                   | uth.<br>:: Aft<br>e fun   | atio              | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation   |   | M                          | 1 ☐ Yes 2 ☐ No   |  |                               |                                     |
| S                                   | I or Attending Physicien: The I after death. Director: After this certificate ha Lin by the funeral director, page  | ifica             | 3 Suicide 6 Could not l   | 286. Place of injury - At nome, i                               | farm, street, factor       | y, office  | 28f. Location (Street<br>City or Town, Sta | and Number or Rural           | Route Number,                       |
| á                                   | afte<br>afte<br>Dir   | Certification:    | 4   Hollidge  | building, etc. (Specify)  |                            |  | Only of Yours, Siz                         | 110)                          |                                     |
|                                     | spite   |                   | 29a. Certifier 1 Certifying P   | hy <b>sician</b> : To the best of my knowledg                   | ge, death occurred         | at the time, date and place                              | , and due to the cause                     | (s) and manner as sta         | ated.                               |
|                                     | To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the | Medical           | (Check only 2 Medical Exa   | miner: On the basis of examination a<br>and manner stated.      | ind/or investigation       | n, in my opinion, death occu                             | rred at the time, date a                   | nd place, and due to          | the cause(s)                        |
|                                     | o thi<br>o thi<br>ompi  | Me                | 29b. Signature and title of certifier   |   | 29                         | c. License number  | 29d. [                                     | Date signed (Month, L         | Day, Year)                          |
| )                                   | ->-0  |                   | ) C Fant  | with Ir as  |                            | 20063253   |  | 6.10.06                       | r<br>In                             |
| •                                   |   |                   | 30. Name and address of person who  | completed cause of death (Item 23a                              | ) (Type, Print)            |  |  |                               |                                     |
|                                     |   |                   |   |   |                            | 100 0  | 21:11 4. 3                                 | 2.112                         |                                     |
|                                     |   |                   | - Enneit bek  | B JRMD. Y28   | W. Manl                    | COTOF. DADW  | 4,11, MO                                   | 11003                         |                                     |
|                                     | Sta   | ate .             | C. Ennest 6.2   | 32. Registrat's Signaline                                       | w. Marl                    | CETST. JHOW  | 4,11, ME                                   | 11863                         |                                     |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 29, 3:10 A.M June 2006 **Placious** Teresa Marie /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wilson Health Care Center Montgomery Gaithersburg If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Director 79 Yrs. Sept.25, 1926 208-16-7149 PA. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28e-f show the Medical Exemples must be notified at 1 X Yes 2 No Maryland | Montgomery Gaithersburg Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 221 Booth Street, # 303 20878 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. sut: if Item 27 is marked other than "natural", or Items 23 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No þ Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Administrative Assistant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 Booth Street, # 303, Gaithersburg, MD. 20878 Robert C. Placious/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State in the same 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If sny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) St Rose of Lima Cem. 7/3/2006 Gaithersburg, MD. Sign to of Funeral S Wes Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death CANCER GASTRIC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DYSPHAGIA 1 Yes 2. No 3 Probably 4 Unknown Completed DEMENTIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No has autopsy performed? 1 Yes 2 No 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospitel or Attendi within 24 hours after death. To the Funers! Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D35791 Merlyn Venny pus 30. Name and address of person who completed cause of deaty (Item 23a) (Type, Print) 9801 Georgia Avenue, Silver Spring, Maryland 20902 Merlyn Vemury, M.D.,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

|            |  |               | 1 - For<br>Stata<br>Registrar   | State of Marylar  |                             | epartment of I<br>C <i>ertificate of</i>                 |  |   | iene<br><sub>eg. No.</sub>           | )6                                    | 22652  |
|------------|--|---------------|---|---|-----------------------------|--|--|---|--------------------------------------|---------------------------------------|--|
|            | Physici  |               | Decedent's Name (First, Middle, Last Charlean Ann Page)   | *   |                             |  |  | 2. Date of Dea<br>Month                     | Day                                  | Year                                  | 3. Time of Death                                   |
|            | /Medic<br>Examin   |               | 4a. Facility Name (If not institution, give   |   |                             | 4b. City, Town, o  | or Location of Death                       | June 27                                     | 4c. County o                         | f Death                               | 8:49 P™  |
|            | Funeral<br>Director  |               | Holy Cross Hospi 5. Social Security Number 6. S 478-16-3531   |   |                             |  | Spring If Under 24 Hrs. Hours Min.         | 8. Date of Birth (Month, Day,               | Year)                                | 9. Birthp<br>Coun                     | gomery<br>lace (State or Foreign<br>try)           |
|            | pu 🛦   |               | Usual Residence of Decedent  10a. State 10b. County   | 10c Ci  |                             | or Location  |  |   |                                      |                                       | Od. Inside City Limits                             |
|            | Aaryla<br>r sho  | ŏ             |   |   |                             |  |  |   |                                      | 1                                     | 1 Tyes 2 ANo                                       |
|            | deeth with the Maryland<br>ms 23e or 28e-f show<br>rount be pullified at   | Director      | Maryland Montgom<br>10e. Street and Number<br>10606 Dunkirk D   | <i>-</i>  | lver                        | Spring<br>10f. Zip Code                                  | 902  | 1   | 0g. Citizen of WI                    |                                       | itry?  |
| S<br>S     | n 72 hours after deeth with the Marylar<br>"naturel", or Items 23e or 28a-f show<br>edical Examinat must be redified at    | by Funeral    | 11. Marital Status 1 Never Married  Married   | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 2 X No<br>If Yes, Give                         | .s.                         | 13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No | tispanic Origin? (S<br>an, Mexican, Puert  | pecify Yes or No-<br>o Rican, etc.)         | 14. Race                             | , White, e                            |  |
| 12-0036    | 72 hours<br>"naturel"  | leted b       | 3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest gra   |   | (                           | Decedent's Usual Occup<br>Give kind of work done         | during most of wor                         | king  | 16b. Kind of Bus                     |                                       |  |
| 7 7        | filed within 72<br>Hygiene.<br>other then "na'<br>ent, the Medic   | Completed     | Elementary/Secondary (0-12)   | College (1-4or 5+)  |                             | ife. DO NOT use retire<br>omemaker                       |  |   |                                      | Own_                                  | Home   |
| and        | e d it b   | Be            | 17. Father's Name (First, Middle, Last) Roland Utley  |   |                             |  |  | ne (First, Middle, I                        | Maiden Sumame                        | )                                     |  |
| <u> </u>   | 2 should<br>and Men<br>is marke<br>surnatic  | P             | 19a. Informant's Name/Relationship (1   | vna Print)  | 19h /                       | Mailing Address (Street                                  | Faye T                                     |   | City or Town S                       | toto Zin                              | Codel  |
| Z          | and 2 s<br>ealth an<br>n 27 is   |               | Dario Pagliai/ H  |   |                             |  |  |   |                                      |                                       |  |
| sattimore, | nit. Pages 1 and 2 should<br>ertment of Health and Men<br>ortant: If Item 27 is marke<br>injury or other traumatic<br>8.   |               | 20a. Method of Disposition  IX□ Burial 2 □ Cremation 3 □  | Removal from State  | elace of L<br>cometery.     | 06 Dunkirk Disposition (Name of crematory or other pla   | се) .Т., Т.                                | Date<br>y 1,                                | 20c. Location - C                    | ity or To                             | wn, State  |
|            | entme<br>ortani<br>injury  |               | 4 ☐ Donation 5 ☐ Other (Specify<br>21. Signature of Funeral Service Licen   |   | re or                       | Heaven Cemete  | es of Facility                             | Delt.                                       |                                      |                                       | g, Maryland  |
| ñ          | permit. Depertr Imports eny inj  |               | Ague SE   | Jackey  |                             | Francis J<br>500 Unive                                   | rsity Blv                                  | d, W, Si                                    | lver Spi                             | nc.<br>cing                           | , Md 20901   |
|            | Physician<br>/Medical  |               | 23a. Part1. Exter the disease, or comp<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | a. Atherosclero   | tic                         | Vascular D   |  | or respiratory arre                         | est,                                 |                                       | Approximate<br>Interval Between<br>Onset and Death |
|            | Examiner   |               | Sequentially list conditions.   | Due to (or as a conseq  | uence of                    | ):   |  |   |                                      |                                       |  |
|            | cuted<br>nd<br>ransit  | Examiner      | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events  | Due to (or as a conseq<br>c.  | uanna of                    | r  |  |   |                                      |                                       |  |
| 58/60,     | ificate be executed<br>g physician and<br>as the burial-transit  |               | resulting in death) Last  | Due to (or as a conseq  | uence of                    | :  |  |   |                                      |                                       |  |
| 0          |  | fedical       |   | u.  |                             |  |  |   |                                      |                                       |  |
| .O. BOX    | the death certify the ettending ched for use a:  | hysician/M    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome of pregna<br>1 □ Live birth 2 □ Feta<br>4 □ Pregnant at time of d<br>9 □ Unknown | l death                     | 3 Ectopic pregnancy 5 Other (specify)                    | 1  |   | 23d. Date<br>Monti                   |                                       | ry<br>Day Year                                     |
| S,<br>T    | w requires that the de<br>been signed by the<br>should be deteched   | by P          | Part II. Other significant conditions of  |   | ulting in t                 | he underlying cause giv                                  | en in Part I.                              |   |                                      |                                       | e cause of death?                                  |
| cora       | requires<br>been sign<br>should be   | eted          | Diabetes, Alzhein   | er's Disease  |                             |  |  |   |                                      |                                       | ably 4 <del>y</del> ∏Unknown                       |
| E LE       | The la<br>ate hes<br>page 2  | Completed     |   |   |                             |  |  | 24a. Was ar<br>autops<br>perform<br>1 Yes 2 | pried? de                            | ere autop<br>or to com<br>ath?<br>Yes | osy findings available inpletion of cause of 2 No  |
| <u> </u>   | Physician: Th<br>this certificate<br>ral director, pag   | Be            | 25. Was case referred to medical examiner?  | Hospital:   |                             | Oth  |  | th (Check only one                          |                                      |                                       |  |
| o uc       | Phys<br>this<br>aldi   | tlon: To      | 27. Manner of Death 1 XNatural 5 Pending  | 1 ☐ Inpatient 2 ½<br>28a. Date of Injury<br>(Month, Day Year)   | ER/Outp<br>28b. Tin<br>Inji | ne of 28c. Injur   | 4 🗆 Nursing no                             | ome 5 ☐ Reside<br>28d. Describe ho          |                                      |                                       | )  |
| DIVISION   | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Attencompletely filled in by the funer | ertification; | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined   |   | ome, farm                   |  | 165 2 140                                  | 28f. Location (Str<br>City or Town          | reet and Number<br>, State)          | or Rural                              | Route Number,                                      |
|            | Hospita     24 hours     Funeral letely filler   | edical C      | 29a. Certifier 1 A Certifying Phy<br>(Check only one) 2 Medical Exam  | rsician: To the best of my kno<br>iner: On the basis of examina<br>and manner stated.                 | wledge, a                   | death occurred at the tir                                | ne, date and place,<br>pinion, death occur | and due to the ca                           | use(s) and mann<br>ite and place, an | ner as sta<br>d due to                | ated.<br>the cause(s)                              |
|            | To the Hos<br>within 24 h<br>To the Fur<br>completely  | Me            | 29b. Signature and title of certifier   | 101   |                             | 29c. Licens  |  | 29  | d. Date signed (                     | /                                     | 1  |
| }          | 10   |               |   | 1- X G  | 1/2                         | Do   | 64051                                      |   | 6/2                                  | 26                                    | 06   |
|            |  |               | 30. Name and address of person who do   | Glan Ro   | 1 23a) (T                   | BR SPRIN   | MD AKCO                                    | 20910                                       | H, MD                                |                                       |  |
| I          | Sta<br>Registr   |               | 31. Date filed (Month, Day, Year)   | 32 Registrar's Signa  | ture                        | porti  |  |   |                                      |                                       |  |

|                              |   |   | 1 - For State of Maryland / Dep   | partment of Health and Nertificate of Death  | Mental Hygi   |   | 2265   |
|------------------------------|---|---|---|--|---|---|--|
|                              | Physic<br>/Med  | ical                                      | 1. Decedent's Name (First, Middle, Last)  Charlotte D. Peoples  |  | 2. Date of Death<br>Month<br>June 29  | Day Year  | 3. Time of Death   |
|                              | Exam  |   | 4a. Fecility Name (If not institution, give street and number)  Dorchester General Hospital   | 4b. City, Town, or Location of Death<br>Cambridge  |   | 4c. County of Deat<br>Dorches   | h  |
|                              | Funera<br>Director  |   | 5. Social Security Number 222-05-7951 6. Sex 1 M 2 F 86 Yrs.  | If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.  | 8. Date of Birth Feb. 8,  | 1920 9. Birti   | nplace (State or Foreigr<br>untry)<br>Laware   |
| 1                            | the Marylend  | ctor                                      | 10a. State 10b. County 10c. City, Town or L Maryland Dorchester   | ocation<br>Cambridge   |   |   | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No   |
| S                            | ath with the  | ai Dire                                   | 6206 Twin Point Cove Rd.  | 10f. Zip Code<br>21613   | 100   | p. Citizen of Whal Cou<br>US  | untry?   |
| )036<br>)                    | within 72 hours after deeth with the Maryle and an an an an an art and a second than "neture!", or Items 23s or 28s-f sho ha Madical Examiner must be contiled a  | Completed by Funeral Director             | Tes 2 440   | Was Decedent of Hispanic Origin? (Spell of Yes, specify Cuban, Mexican, Puerto   | ecify Yes or No-<br>Rican, etc.)  | 14. Race - Amer<br>Black, White   | ican Indian,   |
| Maryland 21215-0036          | s 1 and 2 should be filed within 72 he<br>fleath and Mental Hygiene.<br>Item 27 is marked other than "netun<br>other treumatic event, the Madical   | Completed                                 | Elementary/Secondary (0-12)  College (1-4or 5+)  Executive:   | dent's Usual Occupation I kind of work done during most of working DO NOT use retired) Cutive Secretary  | ng 16   | b. Kind of Business/li  |  |
| rvland                       | 2 should be filed within and Mental Hygiene. Is marked other than reumatic event, the Mental Hygiene.   | To Be                                     | 17. Father's Name (First, Middle, Last) Wilford Donovan   |  | Emma Ross   | iden Sumame)  |  |
| re. Ma                       | Health and 2 si<br>Health and 2 si<br>tem 27 is r   |   | william A. reopies/spouse 6206  | ng Address (Street and Number or Rura  Twin Point Cove I   | Rd., Camb   | ridge, MD   | 21613  |
| Baltimore.                   | permit. Pages 1 and 2 is Deperment of Health as Important; if Item 27 is any injury or other treughts.  |   | 1 Description 3 Description State 4 Donation 5 Other (Specify)  | ook Cemetery 7/5/2   | 2006 W  | ilmington   |  |
| 68760,                       | Physician /Medical Examiner   | dical Examiner                            | 23a. Panf. Enter the disease or complications that baused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of): | 2. Name and Address of Facility Pune<br>irran—Bromwell Fune<br>18 High St., Cambri<br>er the mode of dying, such as cardiac of<br>Cardioury of A   | r respiratory arrest.   | '21613<br>'45e  | Approximate Interval Between Onset and Death DAY.S   |
| P.O. Box (                   | ires thet the death certific<br>signed by the ettending p<br>d be detached for use as i   | Physician/Me                              | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ 170 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown  | Ectopic pregnancy<br>Other (specify)   |   | 23d. Date of delive<br>Month  | ory<br>Day Year  |
| Division of Vital Records, F | To the Hospital or Attending Physician: The law requires thet the within 24 hours efter death.  To the Funeral Director: After this certificate hes been signed by the completely filled in by the funeral director, page 2 should be detache | Medical Certification; To Be Completed by | Part II. Other significant conditions contributing to dealth but not resulting in the un  Concest in the Hart failure  Per luck of Sease Per luck of Luck  25. Was case referred to medical examiner?  1  | 26. Place of Death ( 3 DOA Cther: 4 Nursing Home  28c. Injury at Work?  M 1 Yes 2 No  et, factory, office 28  occurred at the time, date and place, an astigation, in my opinion, death occurred | 24a. Was an autopsy performed 1 Yes 2 XCheck only one) e 5 Residence id. Describe how in City or Town, Stand due to the cause at the time, date a | 24b. Were autoprior to cordeath? 1 Yes  6 Other (Specify opening) 1 Yes  and Number or Rural ate) | ably 4 Maknown  by findings available in pletion of cause of 2 Maknown  Route Number,  ated.  the cause(s) |
|                              | Star  | e   | Lois Narr, D.O, 100 Bramble Street  | ., Cambridge, MD   | 21613   |   |  |
|                              | Registra  | r   | JUN 8 0 2000 Kleeve &   |  |   |   |  |

|                |  |                | al artist   | partment of Health and Me<br>ertificate of Death   |  | ne<br>No2006 22654  |  |  |  |  |
|----------------|--|----------------|---|--|--|---|--|--|--|--|
|                |  |                | Decedent's Name (First, Middle, Last)   |  | 2. Date of Death   | 3. Time of Death  |  |  |  |  |
|                | Physici  |                | Jashbhai K. Patel   |  | Month  | Day 2006 1520 PM  |  |  |  |  |
|                | /Medio   |                | 4a. Facility Name (If not institution, give street and number)  | 4b. City, Town, or Location of Death   | 9 19   | 4c. County of Death   |  |  |  |  |
|                |  |                | Memorial Hospital   | Easton   |  | Talbot  |  |  |  |  |
|                | Funeral  |                | Social Security Number     6. Sex     7. Age (In yrs. last birthda  | y) If Under 1 Year   If Under 24 Hrs.  <br>Months Days Hours Min.                            | 8. Date of Birth<br>(Month, Day, Ye  | 9. Birthplace (State or Foreign                               |  |  |  |  |
|                | Director   | 2              | 221 - 94 - 4132 18M 2□F 62 Yrs.   | Months Days Hours Min.   | 4-1-4  |   |  |  |  |  |
|                | pu M   |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or  | Location   |  |   |  |  |  |  |
|                | eho  | 5              | MD Caroline Prest   |  |  | 10d. Inside City Limits 1 1 Yes 2 □ No                        |  |  |  |  |
|                | the A  | Director       | 10e. Street and Number  | 10f. Zip Code  | 10-  |   |  |  |  |  |
|                | with a or  |                | 150 Wright Street   | 21655  |  | Citizen of What Country?                                      |  |  |  |  |
|                | leeth  | Funeral        |   |  |  | 14. Race - American Indian,                                   |  |  |  |  |
| (0             | the r  | 표              | Armed Forces? 1 □ Never Married 2 M Married 1 □ Yes 2 No  | l. Was Decedent of Hispanic Origin? (Spec<br>If Yes, specify Cuban, Mexican, Puerto F        | lican, etc.)   | Black, White, etc.  |  |  |  |  |
| 03             | ours after deeth with the Marylan<br>rel', or iteme 23a or 28a-f ehow<br>Examiliar must be notified at | ρ              | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:  | 1 ☐ Yes 2 ■ No Specify:  |  | Specify: Aslan  |  |  |  |  |
| 5-0036         | 72 ho<br>natu  | Completed      | 15. Decedent's Education 16a. Dec<br>(Specify only highest grade completed) (Gr   | redent's Usual Occupation<br>we kind of work done during most of workin                      | 160  | b. Kind of Business/Industry                                  |  |  |  |  |
| 2121           | within<br>then<br>then   | 현              | Flomentary/Secondary (0-12) Cottons (1-4or 5+)  | . DO NOT use retired)  |  | Factory   |  |  |  |  |
|                | e filed w<br>il Hygier<br>other th   | ပ္ပ            | -   | tory worker  |  |   |  |  |  |  |
| ng<br>ng       | be find H off  | Be             | 17. Father's Name (First, Middle, Last) Kalidas B. Patel  | 18. Mother's Name  |  | iden Sumame)<br>Patel   |  |  |  |  |
| <u>~</u>       | 2 should be<br>and Mental<br>le marked c<br>eumatic eve  | ို             |   | Gangab   |  |   |  |  |  |  |
| Maryland       | s 1 and 2 should<br>f Health and Mer<br>frem 27 le marke<br>other treumatic                            |                |   | iling Address (Street and Number or Rural  |  | Dover, De 19901   |  |  |  |  |
|                | s 1 and 2<br>if Health<br>Item 27 I  |                |   |  |  | c. Location - City or Town, State                             |  |  |  |  |
| 100            | 00   |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State   | ematory or other place)  |  | Dover. De   |  |  |  |  |
| Baltimore,     |  |                |   |  |  | FUNERAL CHAPEL  |  |  |  |  |
| Ba             | permit. Depertritimports eny inju  |                | Valler will wh  |  |  | FORD ST, DOVER  |  |  |  |  |
|                |  |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not e   |  |  |   |  |  |  |  |
|                | Physician  |                | Immediate Cause (Finaf  |  |  | Interval Between<br>Onset and Death                           |  |  |  |  |
|                | /Medical   |                | disease or condition resulting in death)  Due to (or as a consequence of):  | \  |  | Days  |  |  |  |  |
|                | Examiner   |                |   |  |  | /   |  |  |  |  |
|                | D =  | ner            | Sequentially list conditions, if any leading to immediate Due to for as a consequence of cause. Enter Underlying  |  |  |   |  |  |  |  |
|                | nd   | Examin         | that initiated events   |  |  |   |  |  |  |  |
| 80,            | e exe<br>cian a<br>urial-  | EX             | resulting in death) Last Due to (or as a consequence of):   |  |  |   |  |  |  |  |
| 8760,          | cate be executed<br>physician and<br>the burial-transit  | dical          | d   |  |  |   |  |  |  |  |
| 9              | ding page as   | /Me            | IF FEMALE:  |  |  |   |  |  |  |  |
| Вох            | eath certifis<br>ettending p<br>for use as   | lan.           |   | ☐Ectopic pregnancy   |  | 23d. Date of delivery  Month Day Year                         |  |  |  |  |
| o.             | at the de<br>by the<br>tached  | Physician/Me   | 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown  | Other (specify)  |  |   |  |  |  |  |
| <u>α</u>       | ± 29 €   |                | Part ff. Other significant conditions contributing to death but not resulting in the  | underlying cause given in Part f.  | 23e. Did tobac   | co use contribute to the cause of death?                      |  |  |  |  |
| ds             | puires<br>n sign<br>ald be   | d by           | Yolvulus  |  | 1 ☐ Yes  | 2 No 3 Probably 4 Unknown                                     |  |  |  |  |
| Ö              | w requ   | lete           | Glorius turnor in brain   |  | 24a. Was an  | 24b. Were autopsy findings available                          |  |  |  |  |
| Vital Records, | The lav  | Completed      |   |  | autopsy<br>performed   | prior to completion of cause of death?                        |  |  |  |  |
| ta             |  | 0              | 25. Was case referred to medical  | 26. Place of Death   | Check only one   | No 1 Yes 2 No   |  |  |  |  |
| Ž              | S 5  | To B           | examiner?  1 ☐ Yes 2 ☐ Np Hospitat: 1 ✓ In atient 2 ☐ ER/Outpati  | 04   | The state of the s | e 6 ☐Other (Specify)  |  |  |  |  |
| J of           |  |                | 27. Manner of Di ath 28a. Date of Injury 28b. Time (Month, Day Year) Injury   | of 28c. Injury at 28   | Bd. Describe how   |   |  |  |  |  |
| <u> </u>       | Attendir<br>death.<br>ctor: Al<br>y the fu   | atlc           | 2 Accident investigation  | M 1 Yes 2 No   |  |   |  |  |  |  |
| Division       | or Attending<br>effer death.<br>Director: After<br>in by the fune                                      | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of fnjury - At home, farm, building, etc. (Specify)  | street, factory, office  | If Location (Stree<br>City or Town, S  | t and Number or Rural Route Number,<br>tate)                  |  |  |  |  |
| Ω              | ospitel or A<br>hours efter<br>unerel Dire<br>ly filled in by  |                |   |  |  |   |  |  |  |  |
|                | To the Hospitel or At within 24 hours effer of To the Funerel Direct completely filled in by           | edical         | 29a. Certifier  (Check only)  Medical Examiner: On the basis of examination and/or one)  Medical Examiner: On the basis of examination and/or and manner stated | ath occurred at the time, date and place, ar<br>investigation, in my opinion, death occurred | nd due to the caus<br>d at the time, date  | e(s) and manner as stated. and place, and due to the cause(s) |  |  |  |  |
|                | ithin 2<br>o the   | Med            | one) and manner stated.  29b. Signature and title of certifier  | 29c. License number  |  | Date signed (Month, Day, Year)                                |  |  |  |  |
|                | ± ₹ 5 8  |                | I akshini Vaidyanathan N  | 1D DO 57749  | 3.   |   |  |  |  |  |
|                |  |                | 30. Name and address of person who completed cause of death (ftem 23a) (Typ   | Print)   | 1 3  | 41462006  |  |  |  |  |
|                |  |                | Lakshmi Vaidyanathan 219 S Washingt   |  | ·  |   |  |  |  |  |
|                | Sta  | te             | 31. Date filed (Month, Day, Year) 32. Registrar's Signature   | on Street, Easton,   | MD 2160  | UL  |  |  |  |  |
|                | State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature                            |                |   |  |  |   |  |  |  |  |

DHMH 17 Rev 1/2001

JASH BYAN PREL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Martha Louise Robinson June 27 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Solomons Nursing Center Solomons Calvert If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1□M 2QF Director 379-26-7723 Feb 11 1919 Mississippi Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or thems 23a or 28a-f ehow any injury or other traumatic event, the Madical Exa. if item at the national and once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Maryland Calvert Lusby Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20657 United States 11678 Little Cove Point Road Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white 3 ☐Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Michigan Public School Elementary/Secondary (0-12) College (1-4or 5+) kitchen manager 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) To Be Oma Gisham Luther Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catherine M. Sheranko -daughter 11680 Little Cove Pt. Rd. Lusby MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) Jul 20c. Location - City or Town, State Date 20a. Method of Disposition 2006 1 対Burial 2 ☐ Cremation 3 ☐ Removal from State MIddleham Chapel Cemetery Lusby Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Thrive Immediate Cause (Final une Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day lor in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 2X No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Dixtetes 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2√ No Hospitel or Attending Physicien: 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 0 this 28d. Describe how injury occurred 27. Manner of Death after death. 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 10052242 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Barth MD 110 Hospital Drive Prince Frederick Maryland 20678 32. Registra Signature 31. Date filed (Month, Day, Year) State JUL 0 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY **Physician** ARTHUR FREDERICK LYLE 2 2006 ROCKE 2:40 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 25 1912 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months 1 X M 2 □ F 337-38-8631 94 New York Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show important: If item 27 is marked other than "natural; or Items 23a or 28a-f show injury or other traumatic event, the Marylail Examinar mast be notified at once. Montgomery Olney 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20832 3613 Queen Mary Drive United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Yes Give Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Consultant Engineering 12 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Anne Halliday Arthur George Rocke 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3613 Queen Mary Drive, Olney, Md. Pamela T. Rocke / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 7/5/06 Alexandria, Va. 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee Bach P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retw Onset and Death Immediate Cause (Final disease or condition **Physician** PNEUMONIA 1 WEEK resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. | 1 Yes 2 No eų! 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by page 2 should be COPD, CHF, CVA, IRREGULAR HEART BEAT 3 ☐ Probably 4 ☑ Unknown 1 □ Yes 2 □ No peed 24b. Were autopsy findings available prior to completion of cause of death? HYPOTHYROID, HIGH CHOLESTEROL 24a. Was an this certificate has autopsy perform 2 No 2 2 No 1 Yes 1 Tyes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending М 1 Tyes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0057630 01-04-2006 lun My) death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of 10301 GEORGIA AVE., #209, SILVER SPRING, MD. ANURADHA ARUN, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 05 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 22657 State of Maryland / Department of Health and Mental Hygiene 2 11 11 5 For State Registre Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Riedel Year **Physician** John 6728/2006 2:50a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2 ☐ F 87 Yrs. Director 518-14-3033 1/27/1919 China Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show other treumatic event, the Mudical Examiner must be notified at MD Montgomery Silver Spring Director 1 Tyes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14813 Harold Road 20905 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No1 9 4 3 -1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 ŏ If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 Widowed 4 Divorced "neturel" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "nt eny injury or other treumatic event, The Mealt 2006. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Meteorologist N.O.A.A. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Erhardt Riedel Carmelia Becher 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey S.Riedel/Wife 14813 Harold Road Silver Spring, Md 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Bunal 2 ☑ Cremation 3 ☐ Removal Irom State Chesapeake Crem. 7/01/06 Beltsville, Md 4 Donation 5 Other (Spenty) 21. Signature of Juneral Service PHILIP D. RINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Urosepsis days /Medical Due to (or as a consequence of): Examiner Paraplegia year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1X Yes 2 □ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 5/30/2005 fall down stairs 9:00p M 1 ☐ Yes 2X No investigation 2XI Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, 4 Homicide 14813 Wn, State) Harold Rd home

or Attending Physician; The law requires that the death certificate be executed Box 68760 P.O. Division of Vital Records, ours after death.

neral Director: A
filled in by the fu To the Hospital or within 24 hours af To the Funeral D completely

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier atticia

29c. License number D51918 29d. Date signed (Month, Day, Year) June 30,2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patricia Tomsko Nay 11119 Rockville Pike G-100 Rockville, Md20852 MD 31. Date liled (Month, Day, Year)

State Registrar 29a. Certifier

(Check only

Medical

JUL 03 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** GENE SWIFT S. 28, June 2006 5:30 P. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 4524 Lawson Barnes Road Crisfield Somerset 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 ∰M 2□ F Yrs. Director 69 1937 214-34-8571 June 26, Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits Item 27 is marked other then "natural", or Items 23a or 28e-1 show other treumatic event, the Wadical Examinar must be notified at Maryland Somerset Crisfield 1 ☐ Yes 2 🛣 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4524 Lawson Barnes Road 21817 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∰ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Machinist Paint Brush Mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles W. Swift Elizabeth Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Virginia Cullen Swift (Wife) 4524 Lawson Barnes Road- Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State ö Department of Importent: If any injury or once. Sunnyridge Memorial Park 7/1/06 Crisfield, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradshaw & Sons Funeral Home Robert H. Bradshaw, & 306 W. Main St.- Crisfield, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 4☐ Pregnant at time of death P.O. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RHEUMATOID ARTHRITIS 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page 2 s certificate has autopsy performed? 1 ☐ Yes 2 No of Vital funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 2**√** No 2 1 Tes 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospitel or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours To the Funeral 152 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier completely and manner stated. To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 07/03/2006 D 48098 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 3 2006 Registrar Clave to fresh

State of Maryland / Department of Health and Mental Hygiene State
Registrar #5, per fh, bg, 7/12/06 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day SHEESLEY 2900 AM 06 VIOLA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KIN Vicinica PRIONO cial Security Number If Under 8. Date of Birth (Month, Day, Year) July 25, 1921 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 200 F Months Days Pennsylvania Director 84 Usual Residence of Decedent wohe ! 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or items 23a or 28e-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Crisfield Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21817 5110 Old Auger Road Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 (2) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. hours after 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: ģ 3 ☑Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Sumame) Be permit. Pages 1 and 2 should be i Department of Health and Mentel i Important: If Item 27 ie marked o Felicia D'Angelo Antonio Sisti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Hampshire Drive - North Hampton, NH 03862 Earl Sheesley, III (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State injury or 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 6/30/2006 Salisbury, Maryland 21. Signature of Funeral Service Licensee

Mary Peth Bradshaw-Pruitt 22. Name and Address of Facility Bradshaw & Sons Funeral Home <u> 306 W. Main Street - Crisfield, Maryland 21817</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 000 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner g physicien and as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ cete has been sig . page 2 should b 1 ☐ Yes 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to comptetion of cause of death? 24a. Was an After this certificete has autopsy perform of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. Be 26. Place of Death Check only one 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Division or Attending 1 Natural 2 Accident 5 Pending death. 1 Tes 2 No investigation efter death filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours of To the Funeral D completely filled in Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury MD. Simona Engi 100 E. Carroll St. m.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Glave & Speck Registrar 0 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Joyce Elaine Slaubaugh 12:47 A 11, July 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Frostburg Frostburg Village Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, April 8 Birthplace (State or Foreign
Country) Social Security Number 6. Sex **Funeral** Min. <sup>Year)</sup> 1949 Months Days Hours 232-80-0848 1 □ M 2 🖫 F 57 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show r then "natural", or items 23s or 28s-1 shovers the Medical Examiner must be notified at Allegany Westernport YOXYes 2 ☐ No Director MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21562 405 Vine United States St. Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Appraiser 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: if Item 27 is marked other any liqury or other traumatic event, ONEs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Dewalt Thelma Α. Soult Wayne 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Vine St., Westernport, Maryland 21562 Edward Slaubaugh/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 07/14/ 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Elk Garden, WV. I.O.O.F. Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home augal 20 111 Church St., Westernport, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 4 cute CevebroVascular **Physician** disease or condition onths resulting in death) /Medical Due to (or as a consequence of) Examiner S- uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 No 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ Sclerosis 1 Yes 2 No 3 Probably 4 Unknown Completed disorder (post stroke) 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? mability Nutrition certificate 2□ No 1 ☐ Yes 2 X No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death [Check only one] Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA ٩ this 28a. Date of Injury (Month, Day Year) After the 27. Manner of Death

1 Natural
2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Injury To the Hospital or Attandit within 24 hours after death. To the Funeral Director: Al M 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. S.L. Sandhir, 48 Tarn Terrace, Frostburg, Maryland 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 2 2006 Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

|   |                | I- For State Registrar  |   | ate of Death  | Reg  | No 5 6 1                                       | 5 97 36                                      |
|---|----------------|---|---|---|--|--|--|
| Physicia<br>Medical Examin  | n/             | Decedent's Name (First, Middle,Last)     Gary Wils                                    | on Simms  |   | 2. Date of Death<br>Month Da<br>July 3, 2006 | ay Year  | 3 Time of Death<br>1610 hrs                  |
|   |                | 4a. Facility Name (if not institution, give str<br>4847 66th Avenue                   | eet and number)                                 | 4b. City, Town, or Location of Death  Hyattsville   | n  | 4c. County of Death<br>Prince George           | 's   |
| Funeral<br>Director   |                |   | 7 Age (In yrs. last birth                       | nday) If Under 1 Year If Under 24Hr.  Months Days Hours Mir   | ,  | MM/DD/YYYY) 9. Birth<br>Foreign<br>20,1948 Cou |  |
| м яшу   | ŀ              | Usual Residence of Decedent  10a. State  10b. County                                  | 10c. City, Town                                 | or Location   |  |  | 10d Inside City Limits                       |
| Aaryland<br>28a-f show  | ģ              | Maryland   Prince Geo   | orge Hyatts                                     | sville<br>  10f Zip Code  | 100  | Citizen of What Coun                           | 1 X Yes 2 No                                 |
| th the Maryland<br>23a or 28a-f sho<br>notified at once   | Dire           | 4847 66th Avenue  |   | 20784   | 1  | United Sta                                     | •  |
| er death wi   | Fune           | 1 X Never Married 2 Married 1 3 Widowed 4 Divorced If Y                               |   | Was Decedent of Hispanic Origin? ( S     If Yes, specify Cuban, Mexican, Puerto     Yes 2 X No specify: |  | 14. Race - Americ White, etc.  Specify: B1a    |  |
| nours a   | a pa           | 15. Decedent's Education (Specify only h  |   | Decedent's Usual Occupation (Give kind of during most of working life DO NOT use ref                    |  | bb. Kind of Business/Ir                        | ndustry                                      |
| 336<br>thin 72 P<br>ne<br>than "r<br>edical E   | Completed      | Elementary/Secondary (0-12)   | College (1-4 or 5+)                             | Line Holder   |  | Private  |  |
| 5-0036<br>The within 77<br>Hygiene<br>d other than  |                | 17. Father's Name (First, Middle, Last)   |   |   | e (First, Middle, Maid                       | •  |  |
| 2121<br>ould be fi<br>Mental  <br>marked<br>ic event,   | To Be          | George Simms  19a. Informant's Name/Relationship (Type                                | Print ) 19b                                     | Ali  Mailing Address (Street and Number or  | ce Terrel Rural Route Number                 |  | Zip Code)                                    |
| 50505   |                | Marvin Simms/Brothe   | r  88   | 67 Roll Right Ct.;  | Columbia,                                    | MD. 2104                                       | 14   |
| F E E   |                | 20a. Method of Disposition  1 Burial 2 X Cremation 3                                  | Removal from State cremato                      | ory or other place)   |  | Oc Location - City or 1                        |  |
| Baltimore, permit Pages I as Department of He Important: If ite Imjury or other in injury or other in   | -              | 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee                 | Metrop  | olitan crematory Jul  22. Name and Address of Facility PQ   |  | Alexandria  1 Homes                            | 1  |
| Baltin<br>permit<br>Departm<br>Importa  |                | ava Jar   | rhell   | 55<br>Fo  | pe Fuenra<br>38 Marlbo<br>restville          | ro Pike<br>, Md. 207                           | 47   |
| Physician<br>/Medical   |                | failure. List only one cause on each  | ine   | et enter the mode of dying, such as cardiac   | or respiratory arrest,                       | shock, or heart                                | Approximate Interval Between Onset and Death |
| Examiner  |                |   | rrhosis of liver to (or as a consequence of):   |   |  |  | Death  |
| A   | -e             | Sequentially list conditions, if any, leading to immediate Due                        | to (or as a consequence of)                     |   |  |  |  |
|   | Examiner       | cause Enter Underlying Cause c.   | to (or as a consequence of):                    |   |  |  |  |
| ecuted<br>and<br>transit  | Ë              | d   |   |   |  |  |  |
| 50,<br>e be eve<br>ysician a<br>burial -  | /Medical       |   |   | perME,g857,7/27/06 TT   |  |  |  |
| \$8760, rrtificate be ling physicilas the buri  |                | IF FEMALE:<br>23b. Was decedent pregnant in the<br>past 12 months?                    | 3c. If yes, outcome of pregnancy Live birth 2   | Fetal death 3 Ectopic pregn   | ancy   | 23d Date of delivery<br>Month Da               | ay Year                                      |
| Box 687 c death certifi   | Physiciar      | 1 Ves 2 No 9 Helenous   | Pregnant at time of death 5                     | Other (Specify)   | 4  |  |  |
| P.O. B<br>that the d  | by Ph          | Part II. Other significant conditions co  | ntributing to death but not resulting           | g in the underlying cause given in Part I.  |  | cco use contribute to the                      |  |
| ords, P.C   | ted            |   |   |   | 1 Yes 2                                      | No 3 Proba                                     | opsy findings available                      |
| corc<br>e law re<br>e has be  | Completed      |   |   |   | autopsy<br>performe                          | prior to co                                    | ompletion of cause of                        |
| ital Recionary The I  | 0              | 25. Was case referred to medical  |   | 26 Place of Death (Check  | only one)                                    | No 1 Yes                                       | s 2 No                                       |
| 'Vita   | To B           | examiner?<br>1 ✓ Yes 2 No   | I Inpatient 2 ER/O                              |   |  | sidence 6 🗸 Other:                             | Scene  |
| Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death  al Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detach  |                | 27. Manner of Death  1 X Natural 5 Pending  | 28a Date of Injury<br>(Month, Day, Year) 28b. 7 | Time of Injury 28c. Injury at Work?  1 Yes 2 No   | 28d Describe how                             | injury occurred                                |  |
| Division Hospital or Attent 24 hours after death Funeral Director: tely filled in by the  | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be                                     | 28e. Place of Injury - At home, fa              | arm, street, factory, office building, etc.   | 28f. Location (Street or Town, State         |  | al Route Number, City                        |
| Divis ospital or A hours after uneral Dire y filled in b  |                | determined 29a Certifier  | (Specify)                                       |   |  | ·  |  |
| Division of Vital Records, P.O. Box 68760, within 24 hours after death  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit | Medical        | (Check only one) 2 Medical Examiner: On   |   | ath occurred at the time, date and place, and<br>nvestigation, in my opinion, death occurred            |  |  |  |
| <u> </u>  | Me             | 29b Signature and title of certifier  | 11/ 0-  | 29c. License number   | - 1  | 9d. Date signed (Moni                          | th, Day. Year)                               |
| We  |                | Maryinte Me   | Shell   | O.C.M.E.  | J  | uly 4, 2006                                    |  |
| الاو  |                | <ol> <li>Name and addless of person who com<br/>Margarita Korell MD. Assis</li> </ol> |   | 111 Penn Street, Baltimore, MD  | 21201  |  |  |
|   | ate            | 31 Date filed (Manth, Day, Year)  | 32. Registrar's Signature                       |   |  | <del></del>                                    |  |
| Regist  | rair           | JUL 2000  | WW AT LOOKE                                     |   |  |  |  |

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Margaret Steward 06 2006 2150 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 2 - 1 9 - 1 9 1 3 6. Sex 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF 577-36-1117 Director Wash. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or iteme 23a or 28a-f show Examiner must be notified at DC Washington 1 Tyes 2X No Director 10g. Citizen of What Country? 10f. Zip Code 20011 604 Oglethorpe St. NW USA deeth v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. tiled within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black þ 3 V Widowed 4 □ Divorced "natural", al Hygiene. d other than "natura event, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental Pages 1 and 2 should be is marked Richard Bailey Tibbs Margaret 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Evelyn Roberts/ niece 604 Oglethorpe St. NW Wash. DC 20011 t Health i 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If ite any injury or ot once. ₩ Burial 2 Cremation 3 Removal from State 7-03-06 Ft. Lincoln Cem Brentwood, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service bicapsee 22. Name and Address of FacilityRonald Taylor II Fun. Ch. 10583 Middleport Ln., White Plains, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Congestive Heart Failure Days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, a y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760 by Physician/Medical ettending for use es 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Records, P. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? End Stage Hepatitis C 1 Yes 2 No 3 Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed?
Yes 20 No certificate 1□ Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this After thi 28a. Date of Injury (Month, Day Yeer) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury death. 1 TYes 2 No Director: 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

21 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 32332 06-27-2006 Name and address of person who completed cause o' death (Item 23a) (Type, Print) DR. S.K. Guppa MD 9801 Georgia Ave., #220 Silver Spring, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 3 2006 Registrar

|                            |   | 1              | For<br>State<br>Registrar   | State of Ma   | aryland      |                    | artment<br>rtificate                             |                         |                    | nd Me                |  | gien<br>Reg. Ne                 | to U U U  | 22660  |
|----------------------------|---|----------------|---|---|--------------|--------------------|--|-------------------------|--------------------|----------------------|--|---------------------------------|---|--|
| ì                          | Physicia<br>/Medic  |                | 1. Decedent's Name (First, Middle, L<br>Ethel V. Shelto   |   |              |                    |  |                         |                    |                      | 2. Date of De<br>June 2                    |                                 | 2006 Year   | 3. Time of Death<br>6:15 a M                       |
|                            | Examin  | er             | 4a. Facility Name (If not institution, g Washington Adve 5. Social Security Number 6.   | entist Hospi  |              | ast birthday)      |  | oma                     | Park If Under 24   |                      | 8. Date of Bir                             | ŗ                               | County of Death  Montgomes  9. Birth              |  |
|                            | Funeral<br>Director   |                | 578 32 1156 Usual Residence of Decedent   | 1□M 2 <b>½</b> F  | 80           | Yrs.               | Months   | Days                    | Hours              | Min.                 | 8. Date of Bir<br>(Month, Da<br>12/20/     | 192!                            | 5 Wash  | ington, DC   |
|                            | death with the Maryland ims 23e or 28e-f show ims 24e notified at   | Director       | MD 10b. County Prince   | Georges   |              | attsvi             |  | Code                    |                    |                      |  | 10g. C                          | itizen of What Cou                                | 10d. Inside City Limits  ↑ Yes 2 No  Intry?        |
| 0000                       |   | by Funeral Di  | 1306 Balfour Co  11. Marital Status  1 □ Never Married 2 □ Married  3 ☆ Widowed 4 □ Divorced  | 12. Was Decedent<br>Armed Forces?                                       |              | i i                |  |                         |                    | in? (Spe<br>Puerto F | cify Yes or No<br>Rican, etc.)             |                                 | 14. Race - Amer<br>Black, White<br>Specify: Bla   | ican Indian,<br>, etc.                             |
| ZIZI3-00                   | d within 72 hours after<br>giene.<br>r then "natural", or Ita<br>the Medical Examina  | Completed      | 15. Decedent's<br>(Specify only highest of<br>Elementary/Secondary (0-12)<br>12th   | Education<br>grade completed)<br>College (1-4or 5                       | 5+)          | (Give              | dent's Usua<br>kind of woi<br>DO NOT us<br>Stati | nk done d<br>se retired | furing most (<br>) | of workin            | g  |                                 | Kind of Business/li                               | ,  |
| yland ,                    |   | To Be C        | 17. Father's Name (First, Middle, La<br>Luther William 3  | Jones   |              |                    |  |                         | Lila               | Dell                 | (First, Middle<br>a King                   | JO                              | nes   |  |
| ге, маг                    | 1 and 2 s<br>Health an<br>am 27 la<br>ther trau   |                | 19a. Informant's Name/Relationship Victoria Wise 20a. Method of Disposition   | Sister  | 20b. PI      |                    | Balfo  | our C                   | Ct., H             | yatt                 | Route Numb<br>Sville                       | , M                             | or Town, State, Zinco 20782  Location - City or T |  |
| Baitimor                   | permit. Peges<br>Depertment of I<br>Important: If It<br>any Injury or o   |                | 1 Donation 3 □ Cremation 3 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lie   | cify)   |              | ingtan N           | ationa   | l Cen                   | etery (            |                      |  |                                 | ington,<br>s Funeral                              | Virginia<br>L Home                                 |
|                            |   |                | 23a. Pant. Enter the disease, or constitution of the constitution | omplications that ceused<br>by one cause on each li                     | the death    | 3                  | 3015 1   | 2th                     | Stree              | t, N                 | IE Was                                     | hin                             | gton, DC  | 20017 Approximate Interval Between Onset and Death |
| 8/60,                      | The taw requires that the death certificate be executed as the table and the attending physicien end in a page 2 should be detached for use as the burtal-transit | dical Examiner | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a. Due to (or as b. Due to (or as c. Due to (or as d. Corr              | a consequ    | m to uence of):  B | o:   | ny                      | dis                | lag                  | se .                                       |                                 |   |  |
| P.O. Box b                 | the death certific<br>y the attending pl<br>ched for use as I   | Physician/Med  | 1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant a<br>9 □ Unknown | 2 Fetal      | death 3            | □Ectopic pr<br>□ Other (sp                       |                         |                    |                      |  |                                 | 23d. Date of delin<br>Month                       | very<br>Day Year                                   |
| rds, P                     | w requires that the de<br>been signed by the<br>should be detached  | þ              | Part II. Other significant condition  | s contributing to death b   | out not resu | ulting in the u    | underlying o                                     | ause give               | en in Part I.      |                      |  | tobacco<br>Yes                  |   | the cause of death?                                |
| II Reco                    | The law re<br>cate hes been<br>page 2 sho   | Completed      |   |   |              |                    |  |                         |                    |                      | 24a. Was<br>auto<br>perf<br>1 Yes          | s an<br>opsy<br>ormed?<br>2/2 N | prior to c<br>death?                              | topsy findings available ompletion of cause of     |
| of Vita                    | Attending Physician: or death, actor: After this certifica by the funeral director, i   | n: To Be       | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  27. Manner of Death   | Hospital: 12 Inpati   | JIV          | ER/Outpatie        |  | DA Other                | er: 4 Nur          | sing Hor             | (Check only<br>ne 5 ☐ Res<br>28d. Describe | idence                          | 6 ☐Other (Specury occurred                        | nfy)   |
| Division of Vital Records, | 5 € 5 ⊆   | Certification: | 1 XNatural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin  | ot be 280 Place of In   | ury - At ho  | ome, farm, st      | М  | 1 🗆                     | Yes 2 □N           |                      | 28f. Location<br>City or To                |                                 |   | ral Route Number,                                  |
|                            | To the Hospital or within 24 hours effe To the Funeral Dir completely filled in   | Medical C      |   | Physician: To the best<br>xaminer: On the basis of<br>and manner s      | of examina   |                    |  |                         |                    |                      |  |                                 |   |  |
| )                          | To the within 2 To the comple   | ×              | 29b. Signature and title of certifier   | _dme  |              | MD.                |  | D                       | 638                |                      |  |                                 | Pate signed (Month                                | 06   |
|                            | (15)  | ate            | 30. Name and address of person w DR. Palma C  31. Date filed (Month, Day, Year)   | HiRumam<br>32. Regist   | LL A         | 7                  | 600  | CF                      | ARROL              | 10                   | AUE  | TAK                             | oma f   | tuk, mb.   |
|                            | Regist  |                | HH 0 3 200  |   | K            | Book               | 25   |                         |                    |                      |  |                                 |   |  |

|   |  |                | For State Registrar   | State of Ma  | •                                   | partment of   |  |                               |   | iene                     | 006                                       | 22664  |   |
|---|--|----------------|---|--|-------------------------------------|---|--|-------------------------------|---|--------------------------|---|--|---|
| P   | hysicia  | an             | Decedent's Name (First, Middle, Las   |  |                                     |   |  |                               | 2. Date of Deat<br>Month                    | h<br>Day                 | 2006                                      | 3. Time of Death                                   |   |
|   | /Medic<br>xamin  |                | Erik F. Sm<br>4a. Facility Name (If not institution, give   | ith<br>street and number)  |                                     | 4b. City, Tox   | wn, or Location                                    | n of Death                    | June  | 4c. Co                   | ounty of Death                            | 9:45p <sup>M</sup>                                 | _ |
|   |  |                | 6619 Rannock Rd.  |  |                                     |   | nesda  |                               |   | Mc                       | ntgome                                    |  |   |
|   | neral<br>ector   |                | 5. Social Security Number 392–44–5618  Usual Residence of Decedent  | 7. Age   | (In yrs. last birthd                | Months D  | ear If Under<br>eays Hours                         | er 24 Hrs.<br>Min.            | 8. Date of Birth<br>(Month, Day,<br>Apr. 21 | , Year) 94               | 9. Bint<br>9. Bint<br>9. Bint             | pplace (State or Foreign<br>waukee, WI             |   |
| Maryland  | ling at  | tor            | 10a. State 10b. County MD Montgome  | ry   | 10c. City, Town or<br>Bethesd       |   |  |                               |   |                          |   | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No             |   |
| th the  | e not  | Director       | 10e. Street and Number  |  |                                     | 10f. Zip Co   | ode  |                               | 1   | 0g. Citize               | n of Whal Co                              | untry?   | _ |
| eth wi  | 4  | rai            | 6619 Rannoch Rd.  |  |                                     | 208   |  |                               |   | ,                        | JSA                                       |  |   |
| Dallilloie, Mai ylailo 412.13-0030 permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. | naturel, or nems 23s of 28s-1 enow                                     | by Funerai     | 11. Marital Status  1 □ Never Married 2(X Married 3 □ Widowed 4 □ Divorced  | 12. Was Decedent E<br>Armed Forces?<br>1 Tyyes 2 1 N<br>If Yes, Give<br>Year or Dates: | 968-<br>974                         | 3. Was Decedent If Yes, specify   |  |                               | cify Yes or No-<br>Rican, etc.)             |                          | Race - Ame<br>Black, White<br>pecify: Whi | e, etc.  |   |
| within 72 hc  | the Medical  | Completed      | 15. Decedent's Ed<br>(Specify only highest grad<br>Elementary/Secondary (0-12)<br>12  | ucation<br>de <i>completed)</i><br>College (1-4or 5+                                   | 16a. De (G                          | ecedent's Usual C<br>live kind of work of<br>e. DO NOT use r<br>IS Term ( | occupation<br>done during mo<br>etired)<br>Care Sp | ost of workin                 | ist   |                          | of Business/I                             | industry<br>Financial                              |   |
| vuld be filed<br>Mental Hygi  | atic event,  | To Be C        | 17. Father's Name (First, Middle, Last) Richard C. Smith  | •  |                                     |   | Gra  | ce Ru                         | (First, Middle, M                           | r                        |   |  | _ |
| INGI<br>d 2 sho<br>lith and   | treum  |                | 19a. Informant's Name/Relationship (7)  Cynthia G. Smith/   |  |                                     | ailing Address (S.<br>9 Rannoc  |  |                               |   |                          |   | ip Code)   |   |
| ages 1 er   | y or other   |                | 20a. Method of Disposition  1  Bunal 2  Cremation 3  4  Donation 5  Other (Specify  | Removal from State   | 20b. Place of Di<br>cemetery,       | sposition (Name crematory or other  | of<br>or place)                                    |                               | oate :                                      | 20c. Loca                | tion - City or                            |  |   |
| Definit. Pages<br>Department of   | eny injur<br>eny injur<br>once.  |                | 21. Signature of Funeral Service Licen  |  |                                     | 22. Name and A<br>4510 Wil  | Address of Fac                                     |                               | phy Fund                                    | eral                     | Home                                      |  |   |
| Dhya  | ieian  | 11             | 23a. Part1. Enter the disease, or compshock, or heart failure. List only of   | ilications that caused to one cause on each line                                       | the death. Do not                   |   |  |                               |   |                          | , 2220                                    | Approximate<br>Interval Between<br>Onset and Death |   |
| /Me   | ician<br>dical<br>niner  |                | disease or condition resulting in death)  | Due to (or as a  | consequence of):                    | ccela   | v mo   | lane                          | MA  |                          |   | / Week   |   |
| cuted   | ansit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events | Due to (or as a  | consequence of):                    | cun a   | /_//\@   | (uno                          | <i>//W</i>                                  |                          |   |  | _ |
| certificate be executed   | hysicien and<br>the burial-transit                                     | ical           | resulting in death) Last  | Due to (or as a  | a consequence of):                  |   |  |                               |   |                          |   |  |   |
| O. DOX OG<br>he death certifica   | been signed by the attending phys<br>should be detached for use as the | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown                 | 2 Fetel death                       | 3 ☐ Ectopic pregr   |  |                               |   | 236                      | d. Date of deli<br>Month                  | very<br>Day Year                                   |   |
| ords, r.O   | n signed by<br>uld be deta   | þ              | Part II. Other significent conditions co  | ontributing to death bu  | it not resulting in th              | e underlying caus   | se given in Par                                    | rt I.                         |   | oacco use                |   | the cause of death?                                |   |
| The law req   | ete hes bee<br>page 2 shoi   | Completed      |   |  |                                     |   |  |                               | 24a. Was a autops perform                   | ned2                     | prior to death?                           | topsy findings available completion of cause of    |   |
| OI VILAI<br>Physician:  | ector,   | Be             | 25. Was case referred to medical examiner?  | Hospital:  |                                     |   |  |                               | (Check only on                              |                          |   |  | _ |
| Attending Physic death.   | After this certificete hes<br>funeral director, page 2                 | tion: To       | 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Injun<br>(Month, Day  |                                     |   | Injury at Work?                                    | 1                             | ne 5 Neside<br>28d. Describe ho             |                          |   | sity)  | - |
| DIVISION  To the Hospital or Attending within 24 hours after death.   | it Director  | Certification: | 3 Suicide 6 Could not be determined   |  | iry - At home, farm<br>:. (Specify) | , street, factory, o  | office   |                               | 28f. Location (St<br>City or Town           | reet and l<br>n, State)  | Number or Ru                              | ral Route Number,                                  | _ |
| ne Hospit.<br>n 24 hours  | o Funera   | edical (       | 29a. Certifier 1 Certifying Ph<br>(Check only 2 Medical Exen  | ysicien: To the best on the basis of and manner state                                  | examination and/o                   | leath occurred at I   | the time, date<br>my opinion, d                    | and place, a<br>leath occurre | and due to the ca                           | ause(s) ar<br>ate and pl | nd manner as<br>ace, and due              | stated.<br>to the cause(s)                         | _ |
| To the H  | Comp   | Z              | 29b Signature and title of certifier  | Stugle   | es MC                               | )   | ollo 2   | 557                           | 2   | 9d. Date :               | signed (Month                             | 29/06  |   |
| RI  | 8)   |                | 30. Name and address of person who marubeth S Hughesh   | completed cause of de  | eath (Item 23a) (Ty                 | pe, Print   | L CRC  | en 3w                         | 5940 M                                      | SC I                     | 201 Be                                    | ihosdaM2085  | 2 |
|   | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)   | 30. Registra   | ar's Signature                      |   |  |                               |   |                          |   | OUC.   | 1 |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|  |                               | 1 - State<br>Registrar  | State of M  | aryland / Depa<br><i>Cei</i>                                  | rtificate of   |   | Re                                    | eg. No. 4000                                    | 2266   |
|--|-------------------------------|---|---|---|--|---|---------------------------------------|---|--|
| Physicia<br>/Medic   |                               | Decedent's Name (First, Middle, Last)     Jerry Alan Shoup  |   |   |  |   | 2. Date of Death Month July 5         | Day Year  | 3. Time of Death 2:35 A                        |
| Examin   |                               | 4a. Facility Name (If not institution, give s<br>Casey House  | treet and number)   |   | 4b. City, Town, or Rockvill                                | r Location of Death                                     |                                       | 4c. County of Death Montgomer                   |  |
| Funeral<br>Director  |                               | 5. Social Security Number 6. Sex X  | 7. Ag   | ge (In yrs. last birthday)<br>67 Yrs.                         | If Under 1 Year<br>Months Days                             | If Under 24 Hrs.<br>Hours Min.                          | 8. Date of Birth (Month, Day, Feb 17, |   | hplace (State or Foreig<br>untry)<br>nsylvania |
| yland  |                               | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City, Town or Lo   | cation   |   |                                       |   | 10d. Inside City Limit                         |
| the Mar<br>28a-f el  | rector                        | Maryland Montgomes  10e. Street and Number  | У   | Germantown  | 10f. Zip Code  |   | 10                                    | 0g. Citizen of What Co                          | 1 ☐ Yes 24 N                                   |
| 23e or   | ral DI                        | 19225 Misty Meadow  |   |   | 20874  |   | τ                                     | JSA   |  |
| 72 hours after death with the Maryland<br>naturei', or items 23e or 28e-f ehow<br>alsel Examinar must be notified at   | by Fune                       | 11. Marital Status  1 □ Never Married 2 🕅 Married  3 □ Widowed 4 □ Divorced   | 12. Was Decedent<br>Armed Forces?<br>1 XYes 2 ☐<br>If Yes, Give<br>Year or Dates: | No  | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2X No | lispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)      | 14. Race - Ame<br>Black, White<br>Specify: Whi  | e, etc.  |
| c * 34   | Completed by Funeral Director | 15. Decedent's Edu<br>(Specify only highest grade<br>Elementary/Secondary (0-12)  | cation  | 16a. Dece<br>(Give<br>life.                                   | DO NOT use retired   | during most of work                                     | ring                                  | 16b. Kind of Business/l                         | Industry                                       |
| 2 should be filed withir<br>and Mental Hygiene.<br>Is marked other then<br>aumatic event, the M.   | Be Co                         | 12<br>17. Father's Name (First, Middle, Last)   |   | Manage  | er   | 18. Mother's Nam  |                                       | Grocery Sto<br>Maiden Sumame)                   | ore  |
| d Mental be f<br>marked of<br>matic eve  | To B                          | Wilbur Fazier Shou  | -   |   |  | Anne Mae  |                                       |   |  |
| aith and<br>27 is n  |                               | 19a. Informant's Name/Relationship (Ty<br>Delores J. Whalen/t   |   |   |  |   |                                       | City or Town, State, 2<br>rmantown, M           |  |
| Pa Tr  |                               | 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)   | emoval from State   | 20b. Place of Dispo<br>cometery, crei<br>Chesapeal            | esition (Name of<br>matory or other place<br>ke Cremat     | ory 07/0  |                                       | 20c.Location·City or Beltsville,                |  |
| permit. Departm Importa eny inju   |                               | 21. Signature of Funeral Service License  | 7. GH   |   |  |   |                                       | ce P.O. Bo<br>Clarksvill                        |  |
| Physician /Medical Examiner physician and physician street physician stree | edical Examiner               | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as   | a consequence of):  a consequence of):  a consequence of):    |  |   |                                       |   |  |
| daath certif<br>e attending<br>od for use a  | Physician/Medi                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   |   | 2 Fetal death 3   | Ectopic pregnancy Other (specify)                          | ,   |                                       | 23d. Date of deli<br>Month                      | ivery<br>Day Year                              |
| w requires that the<br>been signed by the<br>should be detache   | þ                             | Part II. Other significant conditions con   | ntributing to death I   | out not resulting in the u                                    | nderlying cause giv  | en in Part I.   |                                       | pacco use contribute to                         |  |
| The law<br>ate hes b<br>page 2 sl  | Completed                     |   |   |   |  |   | 24a. Was an autops perform            | y prior to α<br>negd? death?                    | topsy findings availa<br>completion of cause   |
| ding Physiclan: Th<br>h.<br>After this certificate<br>funeral director, pag  | lon: To Be                    | 27. Manner of Death 1 2 Natural 5 Pending   | lospital: 1  Inpat<br>28a. Date of Inj<br>(Month, D                               |   | f 28c. Injur<br>Wor  | er: 4 ☐ Nursing Ho<br>y at<br>k?                        |                                       | e)<br>ence 6XIOther (Spec<br>ow injury occurred | city) hospice                                  |
| r Attenter deat  | Certification:                | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined   | 28e. Place of Ir<br>building, e   | jury - At home, farm, st<br>tc. (Specify)                     |  | Yes 2 □No   | 28f. Location (St.<br>City or Town    | reel and Number or Ru<br>1, State)              | ıral Route Number,                             |
| To the Hospitel of within 24 hours of To the Funerei D completely filled in  | edical (                      | 29a. Certifier 1 X Certifying Phy (Check only one) 2 Medical Exami  | sician: To the bes<br>ner: On the basis<br>and manner s                           | t of my knowledge, deat<br>of examination and/or in<br>tated. | h occurred at the tire<br>vestigation, in my o             | me, date and place,<br>ppinion, death occur             | and due to the carred at the time, da | ause(s) and manner as<br>ate and place, and due | stated.<br>to the cause(s)                     |
| To the within To the comple  | Me                            | 29b. Signature and tyle of certifier  | $\sim$  | mo  | 29c. Licens<br>D356  |   |                                       | 9d. Date signed (Mont) $u1y = 5$ , $2006$       |  |
| 5 E.G.   | te                            | 30. Name and address of person who con Joseph Kaplan, M.D. 31. Date filed (Month, Day, Year)  | . 6001 M  | incaster Mi   |  | ockville,   | MD 2085                               | 5   |  |

|              |  |                     | For State Registrar   | State                             | of Ma                       | ryland            |                                | rtmen                      |                          |                            |                        | lental H                            | ygiene<br>Reg. No         | 2011                                   | 22666   |
|--------------|--|---------------------|---|-----------------------------------|-----------------------------|-------------------|--------------------------------|----------------------------|--------------------------|----------------------------|------------------------|-------------------------------------|---------------------------|--|---|
|              |  |                     | Hegistrar     Decedent's Name (First, Middle  | e, Last)                          |                             |                   |                                | moun                       |                          |                            |                        | 2. Date of D                        | eath                      |  | 3. Time of Death                                    |
|              | Physicia   |                     | Mary Sudano   |                                   |                             |                   |                                |                            |                          |                            |                        | Month July                          | Da<br>74,                 | y Year<br>2006                         | 12:40 A <sup>M</sup>                                |
| )            | /Medic<br>Examin   |                     | 4a. Facility Name (If not institution   | , give street and                 | number)                     |                   |                                | 4b. City,                  | Town, or                 | Location                   | of Death               |                                     |                           | . County of Deat                       |   |
|              |  |                     | Casey House   |                                   |                             |                   |                                | Rock                       |                          |                            |                        |                                     |                           | ntgomer                                |   |
|              | Funeral  |                     | 5. Social Security Number   | 6. Sex<br>1 ☐ M 2 🛣               |                             |                   | ast birthday)                  | If Under<br>Months         | 1 Year<br>Days           | If Under<br>Hours          | 24 Hrs.<br>Min.        | 8. Date of B<br>(Month, D           | irth<br>a <i>y, Year)</i> | 9. Birt                                | hplace (State or Foreign<br>ountry)                 |
|              | Director   |                     | 059-14-6353 Usual Residence of Decedent   |                                   |                             | 8                 | 35 Yrs.                        |                            |                          |                            |                        | Feb 1,                              | , 192                     | 1 New                                  | York  |
|              | and and  |                     | 10a. State 10b. County  |                                   |                             | 10c. City         | , Town or Lo                   | cation                     |                          |                            |                        |                                     |                           |  | 10d. Inside City Limits                             |
|              | Mary   | to                  | Ohio Frankl   | in                                |                             | New               | Alban                          | 17                         |                          |                            |                        |                                     |                           |  | 1 XYes 2 ☐ No                                       |
|              | 1 28a  | lrec                | 10e. Street and Number  | <u> </u>                          |                             | ITCW              | na ban                         | 10f. Zip                   | Code                     |                            |                        |                                     | 10g. Ci                   | tizen of What Co                       | ountry?   |
|              | be filed within 72 hours after deeth with the Maryland Hygiene. Hygiene dethyrithen "naturel", or Items 23s or 28s-f show event, the Medical Examinar must be notified at  | by Funeral Director | 4009 Farber Cou   | rt                                |                             |                   |                                | 430                        | 54                       |                            |                        |                                     | USA                       |  |   |
|              | eep E  | ner                 | 11. Marital Status  | 12. Was f                         | Decedent E<br>d Forces?     | ver in U.S        | S. 13. \                       | Vas Deced                  | ent of Hi                | spanic Ori                 | igin? (Spi             | ecify Yes or N<br>Rican, etc.)      | lo-                       | 14. Race - Ame<br>Black, Whit          |   |
| 2            | or It  | y Fu                | 1 Never Married 2 Marr  | ried 1 🗆 Y                        | es 2X No                    | 0                 | 1                              | 1 ☐ Yes                    |                          | Specify:                   |                        | , , , , , , ,                       |                           | Specify:                               | 0, 0.0  |
| Ś            | ure!   |                     | 3 Widowed 4 □ Divorced  |                                   | or Dates:                   |                   | 16- 0                          | da anta di tarra           | 10                       |                            |                        |                                     | 105 1                     | Wh                                     | ite   |
| 2            | n 72<br>"nat   | Completed           | (Specify only highe   | Ť                                 |                             |                   | 16a, Deced<br>(Give<br>life, I | kind of wo<br>DO NOT us    | rk done a<br>se retired, | turing mos<br>)            | t of work              | ing                                 | 16D. K                    | and of Business                        | industry  |
| 7 7          | withi<br>iene.<br>than   | mo                  | Elementary/Secondary (0-12)   | Colleç                            | ge (1-4or 5-                | -)                | Homem                          |                            |                          |                            |                        |                                     | Own                       | Home                                   |   |
| 2            | Hyg<br>other   | ø                   | 17. Father's Name (First, Middle,   | Last)                             |                             |                   |                                |                            |                          | 18. Mothe                  | er's Name              | e (First, Middi                     | 1 - 11 - 1                |  |   |
| Jana         | Ald be<br>denta<br>rked<br>tic ev  | To B                | Frank Pilolla   |                                   |                             |                   |                                |                            |                          | Rose                       | e Fri                  | izone                               |                           |  |   |
| a<br>S       | s ma   |                     | 19a. Informant's Name/Relations   |                                   |                             |                   | 19b. Mailir                    | g Address                  | (Street a                | and Numb                   | er or Rura             | al Route Num                        | ber, City                 | or Town, State, 2                      | Zip Code)   |
| Ξ            | and 2<br>saith<br>n 27 i   |                     | Sandra Ziets/da   | ughter                            |                             |                   | 4009                           |                            |                          |                            | New                    | Albany                              | , OH                      | 43054                                  |   |
| ore,         | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hydiene.  Department of Health and Mental Hydiene.  Department of Health and Mental Hydiene.  Department of Health and Mental Hydiene.  Department of Hydiene is nextled other than "naturel," or Items 23a or 28a-f ehow eny injury or other traumatic event, its Medical Examinar must be inclined at once. |                     | 20a. Method of Disposition  1 D Burial 2 Commation  | 3 □Removal f                      | rom State                   | 20b. Pl           | ace of Dispo<br>ametery, crer  | sition (Nan<br>natory or o | ne of<br>ther place      | θ)                         |                        | Date                                | 20c. L                    | ocation - City or                      | Town, State   |
| Ĕ            | Pag<br>ment<br>ant:<br>ury c   |                     | 4 Donation 5 Other (S   |                                   |                             | Che               | esapea                         |                            |                          |                            |                        | 06/06                               | _                         |  | , Maryland  |
| baltimor     | Depart<br>Depart<br>Import<br>eny in   |                     | 21. Signature of Funeral Service  | Licensee                          | 011                         |                   | Go <sup>22</sup>               | ing H                      | d Addres<br>OME          | s of Facili<br>Crema       | ation                  | n Servi                             | ice                       | P.O. Bo                                | x 784   |
|              | 705 e d  |                     | doved a   | Litte                             | MAG                         |                   |                                |                            |                          |                            |                        |                                     |                           | arksvil                                | 1e, MD 21029<br>Approximate                         |
|              |  |                     | 23a. Part1. Enter the disease, or shock, or heart failure. List   | only one cause                    | on each lin                 | 0 death           | . Do not ent                   | er (ne mou                 | e or aying               | g, such as                 | Cardiac                | or respiratory                      | arrest,                   |  | Interval Between<br>Onset and Death                 |
| 7            | Physician<br>/Medical  |                     | Immediate Cause (Final disease or condition resulting in death)   |                                   |                             |                   | ailur                          | е                          |                          |                            |                        |                                     |                           |  |   |
|              | Examiner   |                     | ,   |                                   | e to (or as a               | consequ           | ience of):                     |                            |                          |                            |                        |                                     |                           |  |   |
|              | £.   | ē                   | Sequentially list conditions,   | b. Sep                            | S1S                         | DOPSEC            | ianda of):                     |                            |                          |                            |                        |                                     |                           |  |   |
|              | ansit  | Examine             | Sequentially list conditions, if any, leaving to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events | <b>S</b>                          |                             |                   |                                |                            |                          |                            |                        |                                     |                           |  |   |
| <b>-</b>     | be executed<br>ician end<br>burial-transit   | Exa                 | resulting in death) Last  | C. Due                            | e to (or as a               | consequ           | ience of):                     |                            |                          |                            |                        |                                     |                           |  |   |
| 90,          | 0 % 0  | ca                  |   | d.                                |                             |                   |                                |                            |                          |                            |                        |                                     |                           |  |   |
| õ            | leath certificat<br>ettending phy<br>I for use as th   | Med                 | IF FEMALE:  | I                                 |                             |                   |                                |                            |                          |                            |                        |                                     |                           |  |   |
| Z OZ         | th ce<br>tendii  | an/h                | 23b. Was decedent pregnant in the past 12 months?   |                                   | ive birth                   |                   |                                | Ectopic pr                 | egnancy                  |                            |                        |                                     |                           | 23d. Date of del                       | livery<br>Day Year                                  |
|              | O O O  | Physician/Med       | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown   |                                   | Pregnant at i<br>Jnknown    | time of de        | eath 5                         | Other (sp                  | ecify)                   |                            | <del></del>            |                                     |                           | Month                                  | Day   |
| л<br>Э       | The law requires that the site hes been signed by the bage 2 should be detached.   | Ph)                 | Part II. Other significant conditi  | ons contributing                  | to death bu                 | it not resi       | ulting in the u                | nderhina c                 | auca awa                 | an in Part I               | 1                      | 23e Dic                             | 1 tobacco                 | use contribute to                      | the cause of death?                                 |
| Ę,           | signe<br>signe<br>d be   | l by                | cerebrovascular   |                                   |                             |                   | 9                              | indonying o                | auso give                | J                          |                        |                                     |                           |  | robably 4 Unknown                                   |
| Š            | w require<br>been signature  | etec                | CCICOLOVABCATAL   | acciac.                           |                             |                   |                                | _                          |                          |                            |                        |                                     |                           |  |   |
| ě            | he lav   | Completed           |   |                                   |                             |                   |                                |                            |                          |                            |                        |                                     | opsy<br>formed?           | prior to death?                        | utopsy findings available<br>completion of cause of |
| Vital Record |  | ပိ                  | 25. Was case referred to medica   | N -                               |                             |                   |                                |                            |                          | OC Disa                    | 4 D4                   |                                     | 2[XN                      | 1 Tes                                  | 2 No  |
| 5            | ysician:<br>is certific<br>director,   | 0 8                 | examiner?  1 Yes 2 XNo  | Hospital:                         | 1 □ Inpatie                 | nt 2 🗆            | ER/Outpatier                   | at 3□ DC                   | Othe                     |                            |                        | h <i>(Check onl</i> )<br>ome 5 □ Be |                           | 6 € Other (Spe                         | cify) hospice                                       |
| o            | g Phy<br>er thi  | ı.                  | 27. Manner of Death   | 28a. C                            | Date of Injur<br>Month, Day |                   | 28b. Time o                    |                            | 8c. Injury<br>Work       | / at                       |                        | 28d. Describ                        |                           |  | nospite   |
| 0            | ath.<br>rr: After  | atlo                | E C / Novidoni  | igation                           | mornin, buy                 | 1001)             | Injury                         | М                          |                          | Yes 2□                     | No                     |                                     |                           |  |   |
| DIVISION     | il or Attend<br>efter death<br>  Director: .<br>d in by the f  | Certification;      | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ  | nined 288. F                      | Place of Inju-              | ry - At ho        | me, farm, str                  | eet, factory               | , office                 |                            |                        |                                     | (Street a.                |  | ural Route Number,                                  |
| ā            | rs eft   |                     |   |                                   |                             |                   |                                |                            |                          |                            |                        |                                     |                           |  |   |
|              | Hosp<br>4 hou<br>Fune<br>fely file   | cal                 | (Check only 2 Medical   | ng Physician: T<br>Examiner: On t | the basis of                | examinal          | wlodgs, deat<br>tion and/or in | n occurred<br>vestigation  | at the tin<br>, in my of | ne, date as<br>pinion, dea | nd place,<br>ath occur | and dus to the<br>red at the time   | e cause(s<br>e, date an   | l) and it annot as<br>d place, and due | s stated.<br>o to the cause(s)                      |
|              | To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certifical completely filled in by the funeral director.  | Medical             | 29b. Signature and title of certifie  | <i>x</i>                          | manner sta                  | 1 <del>0</del> 0. |                                | 290                        | . License                | e number                   |                        |                                     | 29d. Da                   | ate signed (Mont                       | h. Dav. Year)                                       |
| 1            | 5 1 ¥ 1 8  |                     | , CK-   | M-                                |                             | MI                |                                | -                          |                          |                            |                        |                                     |                           |  | •   |
|              |  |                     | 30. Name and address of perior  | who completed                     | cause of de                 | ath (Ita-         | 23a) (Tunn                     |                            | 5635                     |                            |                        |                                     | July                      | 5, 200                                 | 0   |
|              | 12 E.G.  | 1                   | Joseph Kaplan,  | M.D. 60                           | 01 Mu                       | ncasi             | ter Mi                         | 11 Rd                      | . Ro                     | ckvi.                      | 11e,                   | MD 208                              | 355                       |  |   |
|              | Sta  |                     | 31. Date filed (Month, Day, Year  |                                   | 32. Registra                | ır's Signa        | ture 🚣                         | 1.                         | <i>P</i> N               |                            |                        |                                     |                           |  |   |
|              | Regist   | rar                 | JUL   | 6 200\$                           | DER                         | Mar.              | 15.                            | G10844                     |                          |                            |                        |                                     |                           |  | - N   |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 11:55<sub>A M</sub> July 6, **Physician** 2006 Mae Barber Shackelford /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X**□ F 98 September 30, 1907 Yrs. Maryland Director 577-26-2507 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens. Important: If item 27 is marked other then "naturel", or items 23s or 28s-1 show any rijury or other traumatic event, the Medical Exertination by medical pages. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2**X** No Director St. Mary's Leonardtown Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20650 USA 40540 Parsons Mill Road Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry re kind of work done during most of working . DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Practical Nurse Private Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Shorter William Henry Barber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3725 Massachusetts Avenue, Washington, DC 20019 Gynetha B. Shackelford/Daughter In-Law Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Joseph's Cemetery July 11, 2006 Morganza, Maryland 21. Signaturije of Funeral Service Licensee Marting Lev-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part I. Enter the disease, or complications that caused death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o Physician/Medical Examiner ysicien and e burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ② No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death plut not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? page 2 No 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 2 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours af

To the Funeral D

completely filled in 29a. Certifier tale Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ş 29b. Signature and the of certified 29c. License numbe 29d. Date signed (Month, Day, Year) d cause of death (Item 23a) (Type, Print) 30. Name and add s of person who comp 4035 Three Notch Road, Hollywood, Maryland 20636 Jarboe, M.D. James 1 31. Date filed 32. Reg Registrar

| 900            | -5-7  |                 | 1 - For State Registrar  | State of M   | arylan                       |   |                                    |                              | ealth a<br>Death          | and M                    |   | iene2 (                   | 06                    | 22668   |
|----------------|---|-----------------|--|--|------------------------------|---|------------------------------------|------------------------------|---------------------------|--------------------------|---|---------------------------|-----------------------|---|
| . *            | Physici   | an              | Decedent's Name (First, Middle, Las.   | ()   |                              |   |                                    |                              |                           |                          | Date of Deat<br>Month                   | Day                       | Year                  | 3. Time of Death                              |
|                | /Medi   | cal             | Mary Alice   | Smit   |                              |   | 45 0'5                             | T                            | l continu                 | 4 Dansh                  | July 8                                  | <del>-</del>              | 06<br>ov of Death     | 10:45 a.Mn                                    |
|                | Examir  | er              | 4a. Facility Name (If not institution, give Solomons Nursing   |  |                              |   | 4b. City,                          |                              | Location of               |                          |   |                           | calve                 |   |
|                | Funeral   | 3               | 5. Social Security Number 6. Se  | 7. Ag  | ge (In yrs. I                | ast birthday)                           | If Unde                            | r 1 Year                     | If Under                  |                          | 8. Date of Birth<br>(Month, Day,        |                           |                       | place (State or Foreign                       |
|                | Director  |                 | 213-16-5424 Usual Residence of Decedent  | □ M 2(X)F  | 92                           | Yrs.                                    | MOUTUIS                            | Days                         | Hours                     | IVIIII.                  | Oct.28,                                 | 1913                      | Mary                  | yland   |
|                | Maryland<br>B-f ehow  | ctor            | 10a. State 10b. County  Maryland Calver  | rt   | 10c. City                    | , Town or La                            |                                    | omons                        | }                         |                          |   |                           |                       | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No        |
|                | ith the   | Director        | 10e. Street and Number   |  |                              |   | 10f. Zij                           | Code                         |                           |                          | 10                                      | 0g. Citizen of            | What Cou              | intry?  |
|                | ath w   | rai             | 13325 Dowell Road  |  | <b>C</b>                     |   | ** -                               | 206                          |                           |                          |   | Unite                     |                       |   |
| ,              | d within 72 hours after death with the Maryland siene. I then "natural", or itema 23e or 28e-f ehow the Maclical Examination in the modified at   | by Funeral      | 11. Marital Status  1 □ Never Married 2 □ Married  3 ※ Widowed 4 □ Divorced  | 12. Was Decedent Armed Forces:  1  Yes 2 N If Yes, Give Year or Dates: | ?                            |   | was Dece<br>If Yes, spe<br>1 🗌 Yes |                              |                           | gin? (Spe<br>i, Puerto l | ecify Yes or No-<br>Rican, etc.)        |                           | ack, White            | ican Indian,<br>, etc.<br>nite                |
|                | "natura   | Completed       | 15. Decedent's Ed<br>(Specify only highest grad  | ucation  |                              | 16a. Deced                              | dent's Usu<br>kind of wo           | ork done d                   | turing most               | t of workii              | ng                                      | 16b. Kind of I            | Business/Ir           | ndustry                                       |
| !              | within<br>than "  | dwo             | Elementary/Secondary (0-12)  | College (1-4or   | 5+)                          |   |                                    |                              | erato                     | r                        |   | Comm                      | unica                 | tion  |
| 3              | 를 수를 는  | Be C            | 17. Father's Name (First, Middle, Last)  |  |                              |   | Српот                              | ie op                        |                           |                          | (First, Middle, N                       |                           |                       | CION  |
| Mar y lail o   | 2 should be f<br>and Mental I<br>is marked of<br>aumatic eve  | ToE             | Frederick Clinton  | n Pentz  |                              |   |                                    |                              | A]                        | lice                     | Mary Mu                                 | sgrove                    |                       |   |
| •              | 2 sho<br>and<br>is mu<br>raum   |                 | 19a. Informant's Name/Relationship (T  |  |                              |   | -                                  |                              |                           |                          | l Route Number,                         |                           |                       |   |
| 5              | is 1 and 2 should<br>of Health and Meritem 27 is marke<br>other traumatic   |                 | Frederick R. Ruan 20a. Method of Disposition   | ck / Son   | 20b. P                       | 23205<br>lace of Dispo<br>emetery, crer |                                    |                              |                           |                          | Californ                                | ia, Ma<br>20c. Location   |                       |   |
| 5              | Pages<br>ent of<br>ht: If it  |                 | 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify  |  | '                            | emetery, crer<br>dens o                 |                                    |                              |                           | 7_13_                    | -2006                                   | 0                         | o Me                  | ruland  |
| Daillinoie,    | permit. Pages 1<br>Department of H<br>Important: If ite<br>any injury or ot<br>once.  |                 | 21. Signature of Fun- Al Service License   |  | Gar                          |   |                                    |                              |                           |                          | sfield                                  |                           |                       | eryland                                       |
| ă              | Depa<br>Impo<br>any ic  |                 | Edward N. Brinsfie   | ld, Jr.  | M000.                        |   |                                    |                              |                           |                          |   |                           |                       | 20650-0279                                    |
|                | Cate be executed by sician and busician and busician and she parial-transit   | ical Examiner   | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leaving to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as   | tic                          | Jence of):  Jence of):  RLr.1           | 513                                | a.Le                         | , , ,                     |                          |   |                           |                       |   |
| P.O. Box 68/   | Attending Physician: The law requires that the death certificate be executed crosarb.  r death.  sctor: Atter this certificate has been signed by the attending physicien and y the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome 1  Live birth 4  Pregnant a                       | 2 Fetal                      | death 3                                 | ]Ectopic p<br>] Other (s)          |                              |                           |                          |   | 1                         | ate of deliv          | rery<br>Day Year                              |
|                | juires that<br>signed b   | by              | Part II. Other significant conditions of   | ontributing to death b   | Fuel                         | A                                       | nderlying o                        | 1                            | en in Part I.             |                          |   | acco use cor              |                       | the cause of death?                           |
| vital Records, | The law requir<br>ate has been si<br>page 2 should  | Completed       | citec perais   |  |                              |   |                                    | ,                            |                           |                          | 24a. Was ar<br>autops<br>perform        | red?                      | prior to co<br>death? | opsy findings available ompletion of cause of |
| 20             | sician: Th<br>certificate<br>rector, pag  | 0               | 25. Was case referred to medical   |  |                              |   |                                    |                              | 26. Place                 | of Death                 | 1 Yes 2                                 |                           | 1 🗆 Yes               | ZEJ NO  |
| ><br>5         | Physic<br>this ce<br>al direc   | To B            | examiner?<br>1 🗆 Yes 2 🗷 No  | Hospital: 1 🗌 Inpati   |                              | ER/Outpatien                            |                                    |                              | 4 🗀 🗥 U                   | rsing Hor                | ne 5 🗌 Reside                           | nce 6 □Ot                 | her (Speci            | fy)   |
| 000            | utending Ph<br>death.<br>ctor: After th<br>y the funeral  | ation:          | 27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation  | 28a. Date of Inju<br>(Month, Da  | ury<br>ay Year)              | 28b. Time of<br>Injury                  | M                                  | 28c. Injury<br>Work<br>1 🔲 \ | at<br>:?<br>/es 2 □ I     |                          | 28d. Describe ho                        | w injury occu             | rred                  |   |
| DIVISION       | al or Attends after death   | Certification:  | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined  | 289. Place of in   | jury - At ho<br>tc. (Specify | me, farm, str                           | eet, factor                        | y, office                    |                           | 2                        | 28f. Location (Str<br>City or Town      | reet and Num<br>, State)  | ber or Run            | al Route Number,                              |
|                | To the Hospital or A<br>within 24 hours after<br>To the Funeral Dire<br>completely filled in b  | Medical         | 29a. Certifier Certifying Phyone) Certifying Phyone  | ysician: To the best<br>liner: On the basis of<br>and manner st        | of examinat                  | wledge, death<br>ion and/or in          | n occurred<br>vestigation          | at the tim                   | e, date an<br>pinion, dea | d place, a<br>th occurre | and due to the ca<br>ed at the time, da | use(s) and mate and place | anner as s            | stated.<br>to the cause(s)                    |
| )              | To the To the To the Comple   | Me              | 29b. Signature and title of certifier  | 1-   |                              |   | 29                                 | c. License                   | number                    |                          | 29                                      | d. Date sign              | ed (Month,            | Day, Year)                                    |
|                | . •   |                 | Dave)  | 4 lando  | nn                           | 0                                       | 1                                  | 247                          | 610                       |                          |   | Jul-1                     | 11 2                  | 2006  |
|                |   |                 | 30. Name and address of person and of  | •  |                              |   | -                                  |                              |                           |                          |   |                           |                       |   |
|                | Sac.  |                 | David J. Tardio,  31. Date filed (Month, Day, Year)  |  | Hosj                         |   | Road,                              | Pri                          | nce F                     | rede                     | rick, Ma                                | arylan                    | d 206                 | 78  |
|                | Sta<br>Regist   |                 | JUL 1 2  |  | hai s oignai                 | B 1                                     | So of                              |                              |                           |                          |   |                           |                       |   |

|                     |   | -              | For<br>State<br>Registrar   |                                    | State of                   | Marylan                 | •                             | artment<br>rtificate                    |                        |                              |            | lental H                     | ygien<br>Reg. N   | 7111             | 06                  | 22                     | 669        |
|---------------------|---|----------------|---|------------------------------------|----------------------------|-------------------------|-------------------------------|---|------------------------|------------------------------|------------|------------------------------|-------------------|------------------|---------------------|------------------------|------------|
|                     | 1000  |                | 1. Decedent's Name (First, Mid-   | dle, Last)                         |                            |                         |                               |   |                        |                              |            | 2. Date of I<br>Month        |                   | ay               | Year                | 3. Time                | of Death   |
|                     | Physicia  | -              | Margaret  | Veac                               | h                          | Stoffe                  | ers                           |   |                        |                              |            | July                         | 13,               | 2006             |                     | 4:37                   | a.m. M     |
|                     | /Medic<br>Examin  |                | 4a. Facility Name (If not instituti   | on, give st                        | reet and numb              |                         |                               | 4b. City,                               | Town, or               | Location of                  | of Death   |                              | 4                 | c. County        | of Death            |                        |            |
|                     | LAdmin  | ٠,             | St. Mary's Nu   | rsino                              | Center                     | r                       |                               |   | Leo                    | nardt                        | :own       |                              |                   | St               | . Ma                | rv's                   |            |
| 14                  | Funeral   |                | 5. Social Security Number   | 6. Sex                             | 7.                         | Age (In yrs. I          | ast birthday)                 | If Under                                | 1 Year                 | If Under                     |            | 8. Date of I                 | Birth<br>Day, Yea |                  |                     |                        | or Foreign |
|                     | Director  |                | 261-30-9854   | 101                                | M 2 🕅 F                    | 91                      | Yrs.                          | Months                                  | Day <i>s</i>           | Hours                        | IVIIII,    | Jan.                         |                   | 1915             | Indi                | ana                    |            |
|                     | D   |                | Usual Residence of Decedent   |                                    |                            |                         |                               |   |                        |                              |            |                              |                   |                  |                     |                        |            |
|                     | how   |                | 10a. State 10b. Coun  | ty                                 |                            | 10c. City               | y, Town or Lo                 | cation                                  |                        |                              |            |                              |                   |                  |                     | 10d. Inside            | •          |
|                     | a Ma  | cto            | Maryland St.  | Mary                               | 7 <b>'</b> s               |                         |                               |   | Leon                   | ardto                        | own        |                              |                   |                  |                     | 1 L Ye                 | s 2 🕅 No   |
|                     | 7 28 F  | Director       | 10e. Street and Number  |                                    |                            |                         |                               | 10f. Zip                                | Code                   |                              |            |                              | 10g. C            | Citizen of W     | /hat Cou            | ntry?                  |            |
|                     | 72 hours after death with the Maryland<br>naturel', or Iteme 23e or 28e-f ehow<br>Iteal Examinan must be notified at  | a              | 21530 Port Vi   | ew Ci                              | lrc1e                      |                         |                               |   |                        | 650                          |            |                              |                   | ited             | Stat                | es                     |            |
|                     | dea   | Funeral        | 11. Marital Status  | 12                                 | 2. Was Deced<br>Armed Forc | ent Ever in U.<br>es?   | S. 13.                        | Was Deced                               | ient of Hi             | ispanic Ori<br>n, Mexicar    | igin? (Sp  | ecify Yes or<br>Rican, etc.) | No-               |                  | - Ameri<br>k, White | can Indian,<br>etc.    |            |
| 9                   | or Ite  | T.             | 1 Never Married 2 Ma  | arned                              | 1 ☐ Yes 2<br>If Yes, Give  | <b>X</b> No             |                               | 1 ☐ Yes 2                               |                        |                              |            |                              |                   | Specify:         |                     | ite                    |            |
| 8                   | ours  | d by           | 3X Widowed 4 □ Divorce  | be                                 | Year or Date               | es:                     |                               |   | **                     |                              |            |                              |                   |                  |                     |                        |            |
| 5                   | 72 E #  | Completed      | 15. Decedo<br>(Specify only high  | ent's Educa<br>hes <i>t grad</i> e | ation<br>completed)        |                         | 16a. Dece<br>(Give            | dent's Usua<br>kind of wor<br>DO NOT us | al Occupa<br>rk done d | ation<br>du <i>ring m</i> os | st of work | ing                          | 16b.              | Kind of Bu       | siness/Ir           | ndustry                |            |
| 2                   | within<br>ene.<br>then "  | ldu            | Elementary/Secondary (0-12  | )                                  | Colfege (1-4               | lor 5+)                 |                               |   |                        |                              |            |                              |                   |                  |                     |                        |            |
| 2                   | D 0   | ပ္ပ            |   |                                    | 4                          |                         | Sc                            | hoo1                                    | Teac                   |                              | - 1- 1     | - (Ci 14)-1-                 | 41- A 4- 1-6      |                  | cati                | on                     |            |
| pu                  |   | Be             | 17. Father's Name (First, Middle  | e, Last)                           |                            |                         |                               |   |                        | 18. Mothe                    | er's Nam   | e (First, Midd               | ile, Maide        | an Sumami        | Θ)                  |                        |            |
| yla                 |   | ပ္             | Perley Otto V   |                                    |                            |                         |                               |   |                        |                              |            | May Jo                       |                   |                  |                     |                        |            |
| Maryland 21215-0036 | d 2 should<br>th and Mer<br>7 is marke<br>traumatic   |                | 19a. Informant's Name/Relatio   | nship (Typ                         | e, Print)                  |                         | 19b. Maili                    | ng Address                              | (Street a              | and Numbe                    | er or Rur  | al Route Nur                 | nber, City        | or Town,         | State, Zi           | o Code)                |            |
| _                   | and salth   |                | Carolyn S. Du   | nn /                               | Daught                     |                         |                               |   |                        | w Ci                         |            | Leon                         |                   |                  |                     |                        |            |
| Baltimore           | es 1 and<br>of Healt<br>fitem 2<br>r other  |                | 20a. Method of Disposition<br>1 XBurial 2 ☐ Cremation   | o 3 □Ra                            | moval from St              | 1 ~                     | lace of Dispo<br>emetery, cre | osition <i>(Nan</i><br>matory or o      | ne of<br>ther plac     | e)                           |            | Date                         | 20c.              | Location -       | City or T           | own, State             |            |
| Ĕ                   | O 0   |                | 4 Donation 5 Other  |                                    | movar nom 30               |                         | ington                        | Nati                                    | ona1                   | . Ce.                        | 8-1-       | -2006                        | Ar1               | ineto            | n, V                | irgin                  | ia         |
| atti                | permit. Pag<br>Dep riment<br>Important:<br>any injury o   |                | 21. Signature of Furierat Service   | ser ser                            |                            | 7                       |                               |   |                        |                              |            | nsfiel                       |                   |                  |                     |                        |            |
| Ö                   | Dep<br>Imp  |                | Edward N. Brin  | stiel                              | ld. Sr.                    | M000                    | 40                            |   |                        |                              |            | d, Leo                       |                   |                  |                     |                        |            |
|                     |   |                | 23a. Part1. Enter the disease, shock, or heart faifure. L   | or complic                         | ations that cer            | used the deatl          |                               |   |                        |                              |            |                              |                   |                  |                     | Approxim<br>Interval B | ate        |
| J                   |   |                | Immediate Cause (Final  | ist only one                       | e cause on eac             | en ime.                 |                               | 1                                       |                        | E                            | 80.        | n 01                         |                   |                  |                     | nset and               |            |
| 1                   | Pnysician<br>/Medical   | П              | disease or condition resulting in death)  | _ a.                               | - Due to (e                | rasa con eq             | SQU                           | aw                                      | ny                     | as                           | XW         | VES                          | -1                |                  | - 1                 | N. Col                 |            |
|                     | Examiner  |                |   |                                    | D09 10 (0)                 | as a conseq             | 001                           | 0./                                     | J                      | Toa                          | N          | -En                          | Vera              | 1                |                     | 124                    | 5 >        |
|                     |   | ā              | Sequentially list conditions,   | b.                                 | Due to (u                  | r as a supero           | uenes ut                      | sin                                     | 2                      | Acce                         | 1          | 1 car                        | w                 | رنظ              |                     | 7.                     | 200        |
|                     | ted<br>nsit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | ≺                                  | ,                          | 10                      | 2 2/1/2                       | 2                                       | -11                    | . Λι Δι                      | 00         | 121                          | -                 |                  | -                   | MA                     | What       |
| _                   | and and il-tra  | xar            | that initiated events resulting in death) Last  | c.                                 | Due to (o                  | ras a conseq            | uence o                       | NO)                                     | rrug                   | 1                            | Cy         | 7-                           |                   |                  |                     | 1100                   | 4          |
| 8760                | The law requires that the death certificate be executed as been signed by the attending physicien and cage 2 should be detached for use as the burial-transit | calE           |   |                                    |                            | 10                      | Don.                          | ننارها                                  | $\mathcal{H}$          | NA                           | ne         | 111                          | K                 | )                |                     | UX                     | 1,6        |
| 87                  | phys<br>the   |                |   | d.                                 |                            |                         | ) LUV                         | ary                                     | 70                     | INE                          | 100        |                              | _                 | _                | 4.                  | 1                      | 201        |
| 9 ×                 | death certifica<br>attending pt<br>d for use as t   | Physician/Med  | IF FEMALE:  | 25                                 | Sc. ff yes, outco          | ome of oregon           | ancu.                         | /                                       |                        |                              | 1          |                              |                   |                  |                     |                        |            |
| Вох                 | ath c   | an             | 23b. Was decedent pregnant in the past 12 months?   | 23                                 | 1 Live bir                 | th 2 Feta               | Ideath 3[                     | ⊒Ectopic pr                             |                        |                              |            |                              |                   | 23d. Date<br>Mor |                     | Day                    | Year       |
| -                   | the a   | S              | 1 ☐ Yes 2 █ No<br>9 ☐ Unknown   |                                    | 4∐Pregnai<br>9□ Unknov     | nt at time of d<br>vn   | eath 5[                       | Other (sp                               | ecify)                 |                              |            |                              | -                 |                  |                     | ,                      |            |
| P.0                 | that the ded by the detached  | F.             |   | iaiana                             |                            |                         |                               |   |                        | an in Dani                   |            | 220 D                        | d tabaaa          | a usa santa      | ubuto to            | the cause o            | i doath?   |
| Ś                   | res tha<br>igned<br>be del  | Ď              | Part II. Other significant cond   | Inons con                          | mouning to dea             | un but not res          | uiting in the c               | inderlying c                            | ause givi              | en in Fan i                  | 1,         |                              |                   | _                |                     | bably 4                |            |
| Records,            | w requir<br>been si<br>should   | Completed      |   |                                    |                            |                         |                               |   |                        |                              |            |                              | Yes               | 2 No             | 3   F10             | Dably 4                | _JOHKHOWH  |
| SC                  | e law r<br>has be   | ple            |   |                                    |                            |                         |                               |   |                        |                              |            | 24a. W                       | as an             |                  |                     | opsy finding           |            |
| æ                   | The tage  | E              |   |                                    |                            |                         |                               |   |                        |                              |            |                              | rformed?          | ? d              | leath?              | 2□ No                  |            |
| Vital               |   | 0              | 25. Was case referred to medi   | ical                               |                            | 75-270                  |                               |   |                        | 26. Place                    | e of Deat  | h (Check on                  |                   |                  |                     |                        |            |
| >                   | 8 0 1   | To B           | examiner?<br>1 ☐ Yes 2 <b>②</b> No  | He                                 | ospital:                   | patient 2               | ER/Outpatie                   | nt 3 DC                                 | Oth                    | er: 4 👺 Ni                   | ursing Ho  | me 5□R                       | esidence          | 6 □Othe          | er (Spec            | fv)                    |            |
| of                  |   |                | 27. Manner of Death   |                                    | 28a. Date of               | Injury<br>, Day Year)   | 28b. Time o                   | of 2                                    | 8c. Injun<br>Wor       | y at                         |            | 28d. Describ                 | e how in          | fury occurr      | ed                  |                        |            |
| <u>0</u>            | Attending r death. ector: After by the fune   | te le          | 1 ②Natural 5 ☐ Pen<br>2 ☐ Accident Inve   | ding<br>stigation                  | (NOTE)                     | , Day 16ai)             | Infury                        | М                                       |                        | Yes 2□                       | No.        |                              |                   |                  |                     |                        |            |
| Division            | Attendi<br>er death<br>rector: A<br>by the fi   | 100            |   | ild not be<br>ermined              | 28e. Place o               | of Injury - At he       | ome, farm, st                 | reet, factory                           | y, office              |                              |            | 28f. Location                |                   |                  | er or Rui           | al Route No            | ımber.     |
| ā                   | efte<br>Diri  | Certification: | 4   Romede  |                                    | bullain                    | g, etc. ( <i>Specif</i> | γ)                            |   |                        |                              |            | City of                      | Town, Sta         | 310)             |                     |                        |            |
|                     | splts<br>nours<br>nere  |                | 29a. Certifier 1 Certif   | ying Phys                          | ician: To the b            | est of my kno           | wiedge, dea                   | th occurred                             | at the tin             | ne, date ar                  | nd place.  | and due to t                 | he cause          | (s) and ma       | nner as             | stated.                |            |
|                     | To the Hospital or Attent within 24 hours efter deatl To the Funerel Director: completely filled in by the  | Medical        |   |                                    | er: On the bas             | sis of examina          |                               |   |                        |                              |            |                              |                   |                  |                     |                        | ∋(s)       |
|                     | o thin o thin o mpl   | ₩e             | 29b. Signature and title of cert  | fier                               | 01                         | 1)                      |                               | 290                                     | c. Licens              | e number                     |            |                              | 29d. [            | Date signed      | (Month              | Day, Year,             | )          |
|                     | - s - 0   |                | b th  | 00                                 | + b.                       | 1 ma                    | IX                            | n                                       | T                      | 101                          | (41        | 9                            | 17                | 12               | 7                   |                        |            |
| /                   | ~   |                | 30. Name and addr. s of pers  | on who are                         | mplete                     | of death (Item          | n 23a) /Tun-                  | Prinh                                   | U                      | U                            | 11         | 1                            | _1.               | -10              |                     |                        |            |
| 10                  | 70.   |                | 11  |                                    | 4.D. 1. 2                  | ,                       |                               |   | Dog-                   | l ua                         | 11         | ood M                        | 0211              | and o            | 0626                |                        |            |
| 65                  | Sta   |                | James P. Jark   | alt)                               | 3 Re                       | gistrar's Signa         |                               | OCCII                                   | Road                   | 110.                         | тту W      | Jou , M                      | aryı              | anu Z            | 0030                |                        |            |
|                     | Regist  |                | AUT. I  | <del>4</del> 200                   | 0                          | - d                     |                               | A CO                                    |                        |                              |            |                              |                   |                  |                     |                        |            |

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                                |   |   |  | State of Mar   | ,                             | •                         | cate of   |  |   | eg. No. 🤉 🕦   | 06   | 22676   |  |  |
|--------------------------------|---|---|--|--|-------------------------------|---------------------------|---|--|---|---|--|---|--|--|
|                                | Discosioni di   |   | 1. Decedent's Name (First, Middle, Last)   |  |                               |                           |   |  | 2. Date of Dea<br>Month                     | th L  | Year 3                                       | . Time of Death                                       |  |  |
| į,                             | Physici<br>/Medi  |   | Margaret   | Savo   | У                             |                           |   |  | July  | 1, 200  | 6  | :00P.M.   |  |  |
| 1                              | Examir  |   | 4a. Facility Name (If not institution, give st   |  |                               |                           | 4   |  | Location of Death                           | 4c. County  |  |   |  |  |
|                                |   |   | Manor Care Nurs:  5. Social Security Number 6. Sex   |  |                               | therenal If I             | Under 1 Year                                      | Largo  | P. Date of Birth                            | Prince George'  |  |   |  |  |
|                                | <sub>c</sub> Funeral<br>Director  |   | 219-38-4906  |  | (In yrs. last birt            |                           | nths Days   | Hours Min.   |   | ,1939   | Maryl  | (State or Foreign<br>and                              |  |  |
|                                | land  |   | Usual Residence of Decedent  10a. State  10b. County   | 1  | 10c. City, Towr               | or Location               | n   |  |   | 1   |  |   |  |  |
|                                | e Mary<br>le-fah  | ctor  | Maryland George'   | nce<br>s   |                               | Lanh                      | am  |  |   |   |  | 1 □ Yes 2 No  |  |  |
|                                | ath with the<br>23a or 28<br>stat be no   | Funeral Director  | 10e. Street and Number 9215 5th Stre   |  |                               | 10                        | of. Zip Code                                      | 706  | 1   | 0g. Citizen of V<br>USA   | Vhat Country?                                | hat Country?  |  |  |
| 020                            | be filed within 72 hours aftar death with the Maryland ital Hygiena. d other than "netural", or itama 23a or 28e-f ahow event, the Medical Examinar must be notified at |   | 11. Marital Status 12  1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced  | 2. Was Decedent Ev.<br>Armed Forces?<br>1 ☐ Yes 2☐No<br>If Yes, Give<br>Year or Dates: |                               |                           | Decedent of H<br>s, specify Cuba<br>es 2 1.No     | ispanic Origin? (S<br>n, Mexican, Puerl<br>Specify:                | pecify Yes or No-<br>to Rican, etc.)        | Blac  | e - American li<br>k, White, etc.<br>::Black |   |  |  |
| Baltimore, Maryland 21215-0020 | ithin 72 ho<br>na.<br>nan "netur<br>Nedical   | Completed by  | 15. Decedent's Educa<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   | ation<br>completed)<br>College (1-4or 5+)  |                               | (Give kind<br>life. DO N  | Usual Occupa<br>of work done of<br>OT use retired | during most of wor<br>)  | rking                                       | 16b. Kind of Bu<br>State  |  |   |  |  |
| 2                              | filed with<br>Hygiena.<br>rther than  |   | 17 Fether's Name (First Middle Leat)   |  |                               | וטע                       | mestic  |  |   |   |  | Lai   |  |  |
| and                            | ed fa b   | 18. Mother's Name (First, Middle, Last) Harvey Chew Georg   |  |  |                               |                           |   |  | valgen Surnam                               | Cre   | ek   |   |  |  |
| ΣŽ                             | 2 should be f<br>end Mantal I<br>Is marked ot<br>aumatic eve  | Harvey Chew Georg  19a. Informant's Name/Relationship (Type, Print)  Farl Savov/husband 2405 Kent Village |  |  |                               |                           |   | City or Town.  |   |   |  |   |  |  |
| Š                              | r tra   | Earl Savoy/husband 2405 Kent Village 1  |  |  |                               |                           |   |  |   |   | ,  |   |  |  |
| more,                          | agas 1 and the strain of Haalt t: If itam 2 y or other  |   | 20a. Method of Disposition 1 ◯XBurial 2 ◯ Cremation 3 ◯ Rei 4 ◯ Donation 5 ◯ Other (Specify)   | e) 7   |                               | 20c. Location -<br>Friend |   |  |   |   |  |   |  |  |
| Baltii                         | parmit. Pagas. Department of Important: If its any injury or ot   |   | 21. Signature of Funeral Service Licensee  | ewell F<br>h Road<br>k, MD 2   | unera1                        |                           |   |  |   |   |  |   |  |  |
|                                |   |   |  | oroximate  |                               |                           |   |  |   |   |  |   |  |  |
|                                | Physician /Medical Examiner  al-transit   | Examiner  | Immediate Cause (Final disease or condition resulting in death)  a.  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury | Hypert   | ue to (or as a c<br>: ensio:  | onsequenc                 | e of):  | al Canc  | er  |   |  | set and Death   |  |  |
| Box 68760,                     | The law raquiras that tha death certificate be executed ata has been signed by the ettending physician and paga 2 should ba datechad for use as the bunal-transit       | Medical   | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | ue to (or as a c              | onsequence                | e of):  |  |   |   |  |   |  |  |
|                                | death   | Physician/I   | Part II. Other significant conditions contri   | ibuting to death but r   | not resulting in              | the underly               | ing cause give                                    | n in Part I.   | 23b. Did to                                 | bacco usa con   | tribute to tha                               | causa of death?                                       |  |  |
| , P.O                          | as that tha de<br>ignad by the e<br>ba datechad i   | by Phy  | History of deep  | venous   | throm                         | bosis                     | S   |  | 1 □ Ya                                      | s 2 XNo   | 3 Probably                                   | / 4□Unknown   |  |  |
| ecords                         | law raquira:<br>as bean sig<br>12 should b  | Completed t   | and pulmonary en   | nbolism  |                               |                           |   |  | 24a. Was an perform                         | n autopsy<br>ned?   | availab                                      | utopsy findings<br>le prior to<br>tion of cause<br>n? |  |  |
| <u>=</u>                       |   | Con   |  |  |                               |                           |   |  | i ☐ Ye                                      | s 2LANO   | 1 ☐ Yes                                      | s 2 🗆 No  |  |  |
| Vita<br>V                      | lcian: Th<br>cartificata<br>rector, pa  | Be  | 25. Was case referred to medical examiner?   | spital:  |                               |                           | 011   |  | th (Check only on                           |   |  |   |  |  |
| Division of Vital Records,     | Phys<br>this<br>ral di  | ation: To   | 1 Yes 2 No Ho  27. Manner of Death  17 Natural 5 Pending 2 Accident investigation  | 1 ☐ Inpatient<br>28a. Date of Injury<br>(Month, Day Y                                  | 2 ☐ ER/Out<br>28b. T<br>(ear) |                           | 28c. Injury<br>Work                               |  |   | 5 ☐ Residence 6 ☐ Other (Specity)  Describe how injury occurred |  |   |  |  |
| Divis                          | i de eta  | Certification:  | 3 ☐ Suicide 6 ☐ Could not be determined  | m, street, fa  | actory, office                |                           |   | ation (Street and Number or Rural Route Number,<br>or Town, State) |   |   |  |   |  |  |
|                                | n 24 hours<br>n 24 hours<br>ne Funaral<br>oletely fillad  | edical (  | 29a. Certifier (Check only one) Cartifying Physic 2 Medical Exemine  | clen: To the best of n<br>r: On the basis of ex<br>and manner stated                   | kamination and                | death occu                | urred at the time<br>ation, in my op              | e, date and place<br>inion, death occu                             | , and due to the ca<br>rred at the time, da | use(s) and mai<br>ite and place, a                              | nner as stated<br>and due to the             | cause(s)  |  |  |
|                                | To the vithin 2 To the comple   | Me  | 29b. Signature and title of certifier  |  |                               |                           | 29c. License                                      |  |   | 29d. Date signed (Month, Day, Year)                             |  |   |  |  |
|                                |   |   | 1 July   | عاد  | 2                             | 5                         | D006  | 2116   | Jı  | uly 13  | , 2000                                       | )   |  |  |
|                                | 2   |   | 30. Name and address of person who com<br>Meklit Worknem,  |  |                               |                           |   | Dr. Gı   | reenbel:                                    | e, MD   | 20770  |   |  |  |
|                                | Sta<br>Registr  |   | 31. Date filed (Month, Day, Year)  | 32. Registra   | s Signature                   | H. A                      | berte   |  |   |   |  |   |  |  |

|                     |   |                     | 1 - For<br>State<br>Registrar   | State of Maryland  |  | irtment of   |   | ınd Me                     |  | iene  | 06 2267!   |
|---------------------|---|---------------------|---|--|--|--|---|----------------------------|--|---|--|
|                     | Physici<br>/Medio   | al                  | 1. Decedent's Name (First, Middle, Las  | LEE  |  | Sando  | ER In                                   | JR.                        | Date of Death Month  JUNE                | h   | Year 8:30 AM   |
|                     | Examin<br>Funeral<br>Director   | er                  | 4a. Facility Name (If not institution, give  1. Social Security Number | ins Hospita  | ast birthday)<br>Yrs.                  | DA HIN<br>If Under 1 Ye<br>Months Da   | OF TOUNDER                              | 24 Hrs. 8                  | Date of Birth<br>(Month, Day,<br>July 25 | Baltir<br>Year)                             | nore City  9. Birthplace (State or Foreign Country)  New Jersey              |
|                     | 0   | ector               | Usual Residence of Decedent  10a. State 10b. County  VA Chesapeak   |  | r, Town or Lo                          | ke   |   |                            |  |   | 10d. Inside City Limits 1   Yes 2 □ No                                       |
| 36                  | n 72 hours after death with the Maryland<br>"neturel; or Items 23e or 28e-f ehow<br>solicel Expolitet man be notified at  | by Funeral Director | 104 Bishops Court  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Decedent Ever in U.s. Armed Forces?  1 XYes 2 No ff Yes, Give 1983.                              | 1                                      | 10f. Zip Cod 2332 Vas Decedent of Yes, specify C   | 3<br>of Hispanic Orig<br>cuban, Mexican | gin? (Speci<br>, Puerto Ri | fy Yes or No-                            | Black                                       | - American Indian,<br>, White, etc.<br>White                                 |
| Maryland 21215-0036 | s within 72<br>jiene.<br>r then "nel  | Completed t         | 15. Decedent's Edi<br>(Specify only highest grace<br>Elementary/Secondary (0-12)  | ucation 2006   | 16a. Deced<br>(Give<br>life. L         | lent's Usual Ockind of work do<br>DO NOT use release Chie  | ne during most<br>tired)                |                            | 1  | U.S. Na                                     | vy   |
| aryland             | ed its p  | To Be               | <ol> <li>Father's Name (First, Middle, Last)</li> <li>Daniel Lee Sande</li> <li>Informant's Name/Relationship (T.</li> </ol>  |  | 19b. Mailin                            | g Address (Stre  | Fran                                    | ces L                      | illian                                   | faiden Sumame<br>Simpkir<br>City or Town, S | ns   |
| -                   | ges 1 and 2<br>it of Health a<br>if item 27 is<br>or other tre  |                     | Kristin Sanderli  20a. Method of Disposition 1 XBurial 2 Cremation 3 C  | 20b. Pl  | ace of Dispo                           | Sishops<br>sition (Name of<br>latory or other i<br>Veteral   | olace)                                  | Ches<br>Dat<br>07/05/      | (0005                                    |   | 3323<br>City or Town, State  |
| Baltimore           | permit. Pa<br>Department<br>Importenti<br>any injury  |                     | 4 Donation 5 Other (Specify   | Pich   | St                                     | Cemeter<br>rano &<br>35 Churc  | ry<br>Feefey                            | / Fami                     | ly Fune                                  | eral Hon<br>DE 1970                         | ne   |
| 8760,               | death certificate be executed  Example and including physician and for use as the burial-transit  The part of the | dicai Examiner      | 23a. Part1. Enter the disease, of composhock, or heart failure. Light only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a. Due to (or as a consequ   | rence of):                             | or the mode of the |   |                            | danniz                                   |   | Approximate Interval Between Onset and Death IZ hours                        |
| O. Box 6            | the death certifi<br>y the attending<br>ached for use as  | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  | 23c. If yes, outcome of pregnar<br>1 □ Live birth 2 □ Fetal<br>4 □ Pregnant at time of de<br>9 □ Unknown | death 3                                | Ectopic pregna<br>Other (specify)  |   |                            |  | 23d. Date<br>Mon                            | of delivery<br>th Day Year   |
| cords, P            | v requires<br>been sign<br>should be  | by                  | Part If. Other significant conditions co  | ntributing to death but not resu   | Ilting in the ur                       | iderlying cause  | given in Part I.                        | _                          | 1 □ Ye                                   | s 2 No                                      | oute to the cause of death?  |
| Vital Records,      | CO HALL   | e Completed         | 25. Was case referred to medical  |  |  | -,-  | 26. Place                               | of Death (                 | 24a. Was an autopsy perform 1 Yes 2      | pr<br>led? de<br>letvo 1 [                  | ere autopsy findings available for to completion of cause of lath?  Yes 2 No |
| Division of V       | iling Phys<br>n.<br>After this<br>funeral di  | ation: To B         | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  | Hospitaf: 1 Inpatient 2 It   | ER/Outpation<br>28b. Time of<br>Injury | 28c. lr  | Other                                   | sing Home                  | 5 Resider                                | nce 6 Other                                 |  |
| Divis               | or At   | i Certification:    | 3 Suicide 6 Could not be determined   | 28e. Place of fnjury - At ho building, etc. (Specify   | ·)                                     |  |   |                            | City or Town,                            | State)                                      | r or Rural Route Number,   |
|                     | To the Hospital within 24 hours e To the Funerel I completely filled  | Aedicai             | one) 2 Medical Exam   | sician: To the best of my know<br>iner: On the basis of examinat<br>and manner stated.                   | ion and/or inv                         | estigation, in m   | y opinion, deat                         | h occurred                 | at the time, da                          | te and place, ar                            | nd due to the cause(s)   |
|                     | Will<br>To  | M                   | 29b. Signature and title of certifier  Turcher W  30. Name and address of person who c  | ompleted cause of death (Item  | 23a) (Type, I                          | RES  | OOO                                     | 4                          |  |   | (Month, Day, Year)<br>29, 2006<br>287  |
|                     | O+ IVA<br>Sta<br>Registr  |                     | ANDREW WATT, MD  31. Date filed (Month, Pay, Year)  5   | 32. Redstrar's Signat  | Fe St                                  | parke  | Himoca                                  | 2, M.                      | ARY A                                    | nd 21                                       | 287  |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day 2006 Physician June 2.7 Sylvia Ann Stewart 2:31 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec. 6, 1936 9. Birthplace (State or Foreign Country)
Wash. D.C. **Funeral** Days Hours 1 ☐ M 2 🛣 F 69 577-52-8609 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or itema 23a or 28e-f ehow Examiner must be notified at 1 XYes 2 No Maryland Silver Spring Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7721 Eastern Avenue #32 20912 United States Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. ģ Specify: African American 3 Widowed 4 Divorced "natural" the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Hygiene. Dietician Hospital Department of Health and Mental Hygis Importent: if Item 27 is marked other any injury or other traumatic event, it once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry E. Robinson Lula Branch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael Anthony Stewart (son) 4813 Avondale Rd., Hyattsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/7/06 Harmony Memorial Park Landover, MD 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Funeral Service Licenses lnolow 7400 Georgia Ave. N.W., Washington, D.C. hourses 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or result tory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a c mequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events inding physician and use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 Yes 24□ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 X Certifying Physician: To the best of my anawados, death pround at the time, date and place, and due to the cause(s) and, namer as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29b. Signature and title of certifier 29c. License numbei 29d. Date signed (Month, Pay, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nasreen Kango, MD 7610 Carroll Avenue, /Takoma Park, Maryland 20912 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State 2006 JUL 05 Registrar

Registrar

0 5 2006

|   |  | 1 - For State Registrar  1. Decedent's Name (First, Middle, Last   | State of Maryla   | nd / Depa                                |                | of Hea                                  | Ith and M                         |   | g. No. 2                                       | 006                           | 2267   |  |
|---|--|--|---|--|----------------|---|-----------------------------------|---|--|-------------------------------|--|--|
| Physic<br>/Med<br>Exam  | lical  | M Llock  4a. Facility Name (If not institution, give   | d Snow De   | IN_                                      | 4b. City, To   | own, or Loca                            | ation of Death                    | Jun Jun                                   | 2 <sup>Day</sup>                               | Year<br>2006<br>unty of Death | 0653 A M   |  |
| Funera<br>Directo   | 1  | Howard County  5. Social Security Number  6. Security Number  6. Security Number   |   |  | If Under 1     |   | A<br>Under 24 Hrs.<br>Durs Min.   | 8. Date of Birth<br>(Month, Day,<br>April | Ho<br>L 7 , 1                                  | ward<br>9. Birthol<br>927     | lace (State or Foreign<br>try)<br>MD                 |  |
| ō.  |  | Usual Residence of Decedent  10a. State 10b. County  MD Howard   | 10c. City, Town or Location   |  |                |   |                                   |   | - / / -  |                               | 10d. Inside City Limits 1 ☐ Ves 2 ☐ No               |  |
| th with th  | Funeral Director   | 1975 Daisy Ro  | oad   |  | 10f. Zip C     | ode 217                                 | 797                               | 10  | -  | of What Coun                  | try?   |  |
| MING KIK IS-UUSO  be filed within 72 hours after death with the Maryland hat Hygiene.  d other then "natural", or frems 23s or 28s-1 show event, the Medical Examinar must be notified at | þ  | 11. Marital Status  1 Never Married 2 Married  3 Widowed Divorced  | 12. Was Decedent Ever in L<br>Armed Forces?<br>1 Yes 2 No<br>If Yes, Give<br>Year or Dates: | Was Deceder<br>f Yes, specify<br>1 Yes 2 | _              | ic Origin? (Spexican, Puerto<br>eecify: | pecify Yes or No-<br>Rican, etc.) |   | Race - America<br>Black, White, e<br>ecify: B1 |                               |  |  |
| of filed within 72 hc al Hygiene. I other then "nature vent, the Wedden   | Completed  | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  11th  16a. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)  Domestic   |   |  |                |   |                                   | king                                      |  | of Business/Ind               | lustry   |  |
| Mid y lattic A 1 A 15-0050 nd 2 should be filed within 72 hours af lith and Mental Hygiene. 27 is marked other then "naturel", or r traumatic event, the Medical Exam                     | 0  | 17. Father's Name (First, Middle, Last) Phillip T.   |   |  |                |   | Sa                                | e (First, Middle, Madie Do                | sey  | ,<br>                         |  |  |
| and 2 sh<br>and 2 sh<br>leelth and<br>m 27 is n<br>her traun  |  | 19a. Informant's Name/Relationship (7) Asbury Snowden  | - Son   | 1975                                     | Dai            | sy Ro                                   | Nood                              | ral Route Number,<br>lbine, N             | 1D 2   | 1797                          |  |  |
| permit. Pages 1 a Department of Hee Important: If Item eny Injury or othe   | 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) |  |   |  |                |   |                                   |   |  |                               |  |  |
| Cate be executed  Medical Examiner  the burial-transit  | icai Examiner  | 23a. Part1. Enter the disease, shock, or heart failure. It only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | aDue to (oyas a consec  | quence of):                              | info           | of dying, sur<br>vetto<br>Fune          | n tion                            | or respiratory arre                       | st,  |                               | Approximate<br>Interval Between<br>Onset and Death   |  |
| Physicien: The law requires thet the death certifical this certificale has been signed by the ettending print director, pege 2 should be detached for use as it.                          | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the pas 12 menths? 1 ☐ Yes 2 No 9 ☐ Unknown   | 3c. If yes, outcome of pregn<br>1 □ Live birth 2 □ Feta<br>4 □ Pregnant at time of o        | Il death 3                               | Ectopic preg   |   |                                   |   | 23d.   | Date of deliver<br>Month      | y<br>Day Year  |  |
| w requires that been signed be should be deta   | Ď  | Part II. Other significant conditions con  | ntributing to death but not res   | sulting in the ur                        | nderlying cau  | se given in l                           | Part I.                           |   | accouse o                                      |                               | cause of death?                                      |  |
| I or Attending Physicien: The law requires ta after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be or                              | e Completed  | 25. Was case referred to medical   |   |  |                |   |                                   |   | ed?<br>X No                                    | prior to condeath?            | sy findings available<br>pletion of cause of<br>X No |  |
| hysicienis cert   | To B   | examiner?  | lospital: 1 🗌 Inpatient 2 🗴   | ER/Outpatien                             | t 3□ DOA       |   |                                   | h <i>Check only one</i><br>ome 5□ Resider |  | Other (Specify)               |  |  |
| To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral   | Certification:   | 27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  | 28a. Date of Injury<br>(Month, Day Year)<br>28e. Place of Injury - At h                     | 28b. Time of Injury                      | м              | Injury at<br>Work?<br>1 ☐ Yes           |                                   | 28d. Describe how<br>28f. Location (Stre  | v injury oc                                    | curred                        |  |  |
| ospital or /<br>hours after<br>uneral Dire  |  | 29a. Certifying Phys   | building, etc. (Special   | (y)                                      | occurred at    | the time da                             | te and place,                     | City or Town,                             | State)   | l manage as etc               | tod  |  |
| To the Hospital within 24 hours a To the Funeral I completely filled  | Medical  | (Check only one)  2 Medical Exami  | ner: On the basis of examina and manner stated.   | tion and/or inv                          | estigation, in | icense num                              | , death occur                     | red at the time, dat                      | d. Date sign                                   | gned (Month, D                | ay, Year)  |  |
| 5   |  | 30. Name and address of person who co  | empleted cause of death (Iter   | n 23a) (Type, I                          | Print)         | 057                                     |                                   |   | lun  | 29                            | 2006   |  |
| Si<br>Regis   | tate<br>trar   | 31. Date filed (Month, Day, Year)  | English, I  |  | oli Cec        | iar L                                   | ane C                             | Olumbia                                   | , MI   | 2104                          | 4  |  |

|  |                | For   | State of Maryland   | d / Depa                      |  | lealth and N                                | Mental Hy                             | giene                | 2006                                    | 22675  |  |
|--|----------------|---|---|-------------------------------|--|---|---------------------------------------|----------------------|---|--|--|
|  |                | Registrar/MENC#290penMF7/  1. Decedent's Name (First, Middle, Last)                 | /6/U6,HM,MCO  | 001                           | tineate of                                     | Deam  | 2. Date of De                         | Reg. No.<br>ath      |   | 3. Time of Death                                   |  |
| Physicia<br>/Medic   |                | Antonio Richard Sca   |   |                               |  | ~   | June 2                                | 6, 2                 | 006                                     | 1:18 P M   |  |
| Examin   | er             | 4a. Fecility Name (If not institution, give st                                      | reet and number)  |                               | 4b. City, Town, o                              | r Location of Death                         | 1                                     | 4c.                  | 4c. County of Deeth                     |  |  |
|  |                |   |   |                               |  |   |                                       |                      |   | del  |  |
| Funeral Director   |                | 218-66-6354   |   |                               |  |   |                                       |                      |   |  |  |
| p ,  |                | Usual Residence of Decedent  10a. State 10b. County                                 | 100 Cin   | . Town or Lo                  | antion   |   |                                       |                      |   | Od to day Obyl inda                                |  |
| anyla<br>shov  | _              | Toa. State  | Toc. City   | , TOWITOF LC                  | ocation  |   |                                       |                      |   | 0d. Inside City Limits 1 ☐ Yes 2 ☑ No              |  |
| Rea-f  | Director       | Maryland Anne Aru   | nde1  | Anr                           | apolis   |   |                                       | 44 611               | 4000                                    |  |  |
| with t   | 급              | 10e. Street and Number  |   |                               | 10f. Zip Code                                  |   |                                       | 10g. Citi            | zen of What Cour                        | ntry?  |  |
| s 23   | Funerai        | 917 Breakwater Dri  | VE<br>2. Was Decedent Ever in U.:   | c   12                        |  | 403   | anaitu Van as Na                      |                      | USA<br>14. Race - Americ                | on Indian  |  |
| ter de   | Š              | 11. Marital Status 1. 1. Married 2  Married 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.  | Armed Forces? 1 ☐ Yes 2 ☑ No  | 3.                            | If Yes, specify Cub                            | lispanic Origin? (Sp<br>an, Mexican, Puerto | Rican, etc.)                          |                      | Black, White,                           |  |  |
| irs af   | by F           | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates:  |                               | 1 ☐ Yes 2 🙀 No                                 | Specify:                                    |                                       |                      | Specify:                                | ite  |  |
| 2 hou  | ted            | 15. Decedent's Educ   |   | 16a. Dece                     | dent's Usual Occup                             | pation                                      |                                       | 16b. Ki              | nd of Business/In                       |  |  |
| hin 7<br>n n<br>Medi   | Completed      | (Specify only highest grade Elementary/Secondary (0-12)                             | College (1-4or 5+)  | (Give<br>life.                | kind of work done<br>DO NOT use retire         | during most of word<br>d)                   | king                                  |                      |   |  |  |
| giene<br>giene   | OT             | 12  |   | Servi                         | ce Manag                                       | er  |                                       | Aut                  | o Dealer                                |  |  |
| al Hy<br>al Hy<br>1 oth  | Be (           | 17. Father's Name (First, Middle, Last)   |   |                               |  | 18. Mother's Nam                            | ne (First, Middle,                    | Maiden               | Sumame)                                 |  |  |
| Ment<br>Ment<br>arked  | 2              | Antonio Richard So  | cafone  |                               |  | Margar                                      | et Cond                               | ron                  |   |  |  |
| and and summer   |                | 19a. Informant's Name/Relationship (Typ   | e, Print)   | 19b. Maili                    | ng Address (Street                             | and Number or Ru                            | ral Route Numbe                       | er, City o           | r Town, State, Zip                      | Code)  |  |
| and<br>ealth<br>m 27   |                | Daniel G. Scafone   | Brother   | <u> </u>                      | Columbia                                       | Road E1                                     |                                       |                      | ,Marylan                                |  |  |
| of H le  |                | 20a. Method of Disposition 1   Bunal 2 □ Cremation 3 □ Re                           | CE CE   | emetery, crei                 | sition (Name of matory or other pla            | ce)   | Date                                  | 20c. La              | cation - City or To                     | own, State   |  |
| Par it is  |                | `4 ☐Donation 5 ☐ Other (Specify)  | Gate  | e of H                        | eaven<br>Cemetery                              | June  | 29,2006                               | Si                   | Lver Spr                                | ing. MD  |  |
| permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23a or 28a-f show amounts: it Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ange. |                | 21. Signature of Funeral Service License  | 120   | F 7                           | 2. Name and Addre                              | ss of Facility Collins                      |                                       |                      | •                                       |  |  |
| 0.0 5 9 0  |                | Wilha o   | logel   |                               | 00 Univer                                      | <u>sity Blvd</u>                            | .,W.,Si                               | <u>lver</u>          | Spring,                                 |  |  |
|  |                | 23a. Part1. Enter the disease, or complic<br>shock, or heart failure. List only one | ations that caused the death<br>a cause on each line.                               | . Do not en                   | ler the mode of dyir                           | ng, such as cardiac                         | or respiratory a                      | rrest,               |   | Approximate<br>Interval Between<br>Onset and Death |  |
| Physician  |                | Immediate Cause (Final disease or condition   | Peritoni  | Lis                           |  |   |                                       |                      |   | Oliset and Death                                   |  |
| /Medical<br>Examiner   |                | resulting in death)   | Due to (or as a consequ   | ience of):                    | 11-  | . 4   |                                       |                      |   |  |  |
|  | _              | Sequentially list conditions, b. if any, leading to immediate                       | Due to (or as a consequ   | tech                          | divert   | iculium                                     |                                       |                      |   |  |  |
| ed sit   | nine           | cause. Enter Underlying Cause (Disease or injury                                    | Due to (or as a consequ   | ence or):                     |  |   |                                       |                      |   |  |  |
| be executed<br>icien and<br>burial-transit   | Examiner       | that initiated events c. resulting in death) Last                                   | Due to (or as a consequ   | ience of):                    |  |   |                                       |                      |   |  |  |
| be e   | ai             |   |   | ,                             |  |   |                                       |                      |   |  |  |
| res that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit  | 0              | d.  |   |                               |  |   |                                       |                      |   |  |  |
| certing<br>nding<br>use a  | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant 23  | c. If yes, outcome of pregna  |                               |  |   |                                       |                      | 23d. Date of delive                     | arv  |  |
| death<br>atter   | ciar           | in the past 12 months?  | 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de                                 |                               | Ectopic pregnanc<br>Other (specify)            | у   |                                       |                      | Month                                   | Day Year   |  |
| the oy the   | hysi           | 9 Unknown   | 9□ Unknown  |                               |  |   |                                       |                      |   |  |  |
| ned t  | by P           | Part II. Other significant conditions conf  | ributing to death but not resu  | ılting in the u               | nderlying cause giv                            | en in Part I.                               | 23e. Did t                            | obacco u             | se contribute to th                     | ne cause of death?                                 |  |
| w require<br>been sig<br>should b  |                | septic sho  | ck  |                               |  |   | 10                                    | res 2                | No. 3 □ Prob                            | ably 4 Unknown                                     |  |
| s been si<br>should  | Completed      | DITC  |   |                               |  |   | 24a. Was                              |                      | 24b. Were auto                          | psy findings available                             |  |
| The la<br>te ha  | mo             | metubele  | as does   |                               |  |   |                                       | rmed?                | prior to condeath?                      | mpletion of cause of                               |  |
| an:<br>tifica<br>tor, p  | a)             | 25. Was case referred to medical  | acidosis  |                               |  | 26. Place of Dea                            | 1 ☐ Yes                               | 2) No                | 1 | 2 NO   |  |
| ysici<br>Is cel<br>direc   | To B           | examiner?   | ospital: 1 patient 2  | ER/Outpatier                  | nt 3 DOA Oth                                   | ar.   |                                       |                      | 3 ☐Other (Specifi                       | y)   |  |
| ig Ph<br>ter th<br>neral   |                | 27. Manner of Death  1 Natural 5 Pending  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time o                   | f 28c. Injui                                   | ry at                                       | 28d. Describe I                       |                      |   |  |  |
| andir.   | Certification: | 2 Accident investigation  | ,   | ,=,                           |  | Yes 2 □No                                   |                                       |                      |   |  |  |
| r Atte   | tific          | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At ho building, etc. (Specify                                | me, farm, st                  | reet, factory, office                          |   | 28f. Location (S<br>City or Tox       | Street an            | d Number or Rura                        | I Route Number,                                    |  |
| itel o   | Ç              |   |   |                               |  |   |                                       |                      |   |  |  |
| To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the   | edical         | 29a. Certifier  (Check only one)  1 Certifying Phys 2 Medical Examin                | icien: To the best of my kno-<br>er: On the basis of examinat<br>and manner stated. | wledge, deat<br>ion and/or in | h occurred at the till<br>vestigation, in my o | me, date and place,<br>ppinion, death occur | , and due to the<br>rred at the time, | cause(s)<br>date and | and manner as si<br>place, and due to   | tated.<br>the cause(s)                             |  |
| To th<br>withir<br>To th<br>comp   | Me             | 29b. Signature and title of certifier   | P   |                               | 29c. Licens                                    | se number                                   |                                       | 29d. Dat             | e signed (Month)                        | Day, Year)   |  |
| /  |                | Bull Waste  | - wn  |                               | 02   | 7804  | -                                     | 6                    | <u> </u>                                | 60 G   |  |
| Ś  |                | 30. Name and address of person who con  |   | 23а) (Туре,                   | Print)   |   |                                       | 1                    | - /                                     | 1  |  |
|  |                | Kobert I  | Refersen  | nen                           | AA   | MS/   | tunes.                                | 1/4                  | Met                                     | 21401  |  |
| Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)   | 32. Registrar's Signa   | ture A                        | partie   |   |                                       |                      | -                                       |  |  |

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

06-04593 Gle

| 04593  |                | Please Type or Print in Black Indelible  |                 |                             |                                   |  |
|--|----------------|--|-----------------|-----------------------------|-----------------------------------|--|
| enn D. Sassin  |                | State of Maryland / Department of Health and Me  | lental Hyg      | giene                       | 200                               | c 0007   |
|  |                | 1- For State Certificate of Death  |                 | Reg                         | No LUU                            | 6 2267   |
| Physicia   | an/            | 1. Decedent's Name (First, Middle,Last)  | 2               | Date of Death Month         |                                   | 3. Time of Death                                 |
| edical Exami   | ner            | Glenn D. Sassin  |                 | June 30, 20                 | Day Year<br>) <b>06</b>           | 1509 hrs   |
|  |                | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Locati  | tion of Death   |                             | 4c. County of Deat                | h  |
|  |                | 7886 Americana Circle Apartment 101 Glen Burnie  |                 |                             | Anne Arunde                       | I  |
| Funeral  |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U   | Under 24Hrs.    | 8. Date of Birth            | (MM/DD/YYYY) 9 Bi                 | rthplace (State or                               |
| Director   |                | 158-66-7447   1X M 2 F   35   Yrs   Months Days Ho   | lours Min.      | 08/04/                      | 1970 Forei                        | gn<br>ountry) NJ                                 |
|  | ŀ              | Usual Residence of Decedent  |                 |                             |                                   |  |
| any  | 1              | 10a. State 10b County 10c. City, Town or Location  |                 |                             |                                   | 10d Inside City Limits                           |
| p we d   |                | MD Anne Arundel Glen Burnie  |                 |                             |                                   | 1 X Yes 2 No                                     |
| rylan<br>'a-f's  | 윙              | 10e. Street and Number 10f. Zip Code   |                 | 100                         | Citizen of What Cou               | intry?   |
| e Ma<br>or 28  | Director       | 7886-101 Americana Circle 21060  |                 |                             | nited Stat                        | •  |
| death with the Maryland or items 23a or 28a-f show any must be notified at once.   | 릚              |  | 0               |                             |                                   |  |
| ath w  | Funeral        | 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexi  |                 |                             | White, etc                        | rican Indian, Black,                             |
| er der   | F.             | 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No spec  | o for           |                             | Sanait III                        | • .  |
| rs afturral"   | ē              | 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No spect 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (G |                 | rk done                     | Specify Wh  16b. Kind of Business | ite  |
| hour<br>natu   | ted            | Elementary/Secondary (0-12) College (1-4 or 5+)  |                 |                             | TOD. KING OF BUSINESS             | midustry   |
| 36<br>in 72<br>han   | 읦              |  |                 |                             | A1.21                             | D  |
| with with ber t  | Completed      | 2 Automobile Salesma 17. Father's Name (First, Middle, Last) 18 Mo   |                 | First Middle Ma             | Automobil<br>aiden Surname)       | e Business                                       |
| filed at Hy.   | BeC            |  |                 | Levine                      | alderi Garrianie)                 |  |
| 21215-0036 uld be filed within 7 Mental Hygiene marked other than r event, the Medica  | 0              | 19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and I  |                 |                             | er. City or Town. Stat            | e. Zip Code)                                     |
| and and martic   | -              | Anita F. Sassin / Mother 3285 Hope Drive   |                 |                             |                                   | ,  |
| and 2  |                | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery   |                 |                             | 20c. Location - City o            | r Town, State                                    |
| Or6<br>ges 1<br>rof F<br>ther  |                | 1 X Burial 2 Cremation 3 X Removal from State crematory or other place)  |                 |                             | Township                          |  |
| timent timent rtant  |                | 4 Donation 5 Other Specify Beth El Cemetery  |                 | 3/2006                      | Washingto                         | n, NJ  |
| Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permitnent of Health and Mental Hygiene Anportant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once. |                | 21. Signature of Funeral Service Lensee  22. Name and Address of Fa  Louis Suburb  |                 |                             |                                   |  |
| UP .   |                | M00956 13-01 Broadw.  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a                         | ay, Far         | ir Lawn                     | NJ 07410                          | Approximate Interval                             |
| Physician<br>/Medical:   |                | failure. List only one cause on each line  | as saraido or r | copilatory arros            | st, shoot, or flear               | Between Onset and Death                          |
| Examiner   |                | Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  |                 |                             |                                   | Deall  |
|  |                | bac to (or do a control quarter of).   |                 |                             |                                   |  |
|  | Je.            | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  |                 |                             | <del></del>                       |  |
|  | Examiner       | cause Enter Underlying Cause (Disease or injury that initiated events resulting in (death) Last  Due to (or as a consequence of):                            |                 |                             |                                   |  |
| ted<br>I<br>Insit  | Exa            | events resulting in death) Last Due to (or as a consequence of):   |                 |                             |                                   |  |
| c.O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transit   | dical          | UNPENDED   |                 |                             |                                   |  |
| 50,<br>te be<br>tysici   | led            | IF FEMALE: 23c. If yes, outcome of pregnancy   |                 |                             | 23d. Date of delive               | nv.  |
| Box 68760,  e death certificate be the attending physici ed for use as the buri  | <u></u>        | 23h Was deceded assessed in the  | ctopic pregnanc | су                          | Month                             | Day Year   |
| x 6<br>th cer<br>trendi  | icie           | 4 Pregnant at time of death 5 Other (Specify)  |                 |                             |                                   |  |
| Boo e dear the are ed for  | Physician/Me   | 1 Yes 2 No 9 Unknown 9 Unknown   |                 |                             |                                   |  |
| of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach   | by P           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in   | in Part I.      |                             | acco use contribute to            |  |
| - S E S  | o p            |  |                 | 1 Yes                       | 2 <b>V</b> No 3 Pro               | bably 4 Unknown                                  |
| requestional   | Completed      |  |                 | 24a. Was ar<br>autops       |                                   | utopsy findings available completion of cause of |
| ecc<br>ne lav<br>nte ha  | Щ              |  |                 | perform<br>1 ✓ Yes 2        |                                   | es 2 No  |
| T: Ti  |                | 25 Was case referred to medical 26 Place of De   | eath (Check on  |                             |                                   | 2 10   |
| /ita<br>sicia<br>iis cer   | o Be           | examiner? 1 ✓ Yes 2 No    No   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other   | 4 Nursing       | Home 5 R                    | Residence 6 V Other               | er. Scene  |
| ing Phy<br>After th<br>funeral o   | -              | 27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at V  | Work? 2         |                             | ow injury occurred                |  |
|  | Certification: |  | 2 V No S        | ubject shot                 | self                              |  |
| 'iSic<br>r Atte<br>er de<br>irecte   | fica           | 28e Place of Injury - At home farm street factory office building  | ng, etc. 2      | 28f Location (St            | reet and Number or R              | ural Route Number, City                          |
| Division spital or Attend hours after death meral Director:  | ertii          | 3 ✓ Suicide 6 Could not be determined (Specify) Multi-Family Apt.  | 7               | or Town, Sta<br>886 America |                                   | ment 101, Glen Bur                               |
| Ilospital<br>24 hours<br>Funeral<br>tely filled  |                | 29a Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and   |                 |                             | <del></del>                       |  |
| Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the  | Medical        | one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deat   |                 |                             |                                   |  |
| To To  | Me             | and manner stated  29b Signature and title of certifier  29c License num   | mber            |                             | 29d Date signed (Mi               | onth, Day, Year)                                 |
| 12   |                | Mayane Doubled O.C.M.E.  |                 |                             | July 1, 2006                      |  |
|  |                | 30. Name and address of person who completed cause of death (Item 23a)   |                 |                             |                                   |  |
|  |                | Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltim  | nore, MD 2      | 1201                        |                                   |  |
| -  | tate           |  |                 |                             |                                   |  |
| S<br>Regis   |                | 31 Date filed (Mgrip Day, Year) 2006 32 Registrar's Signature  |                 |                             |                                   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Kraybill 12<sup>Pay</sup> Adeline **Physician** Schafer Margaret Jüľy 2006 3:25pm M /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Glade Valley Nursing & Rehab Center Walkersville Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | Dec 20, 1919 9. Birthplece (State or Foreign Country)
Pennsylvania 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 2X F 236-07-6503 86 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or then "natural", or Itema 23a or 28a-f ehow the Medical Examiner must be notified at Walkersville Maryland Frederick 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21793 56 West Frederick Street U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 (∄Yes. 2□No World If Yes. Give Year or Dates: War I Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 Widowed 4 □ Divorced War II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5-1other then Elementary/Secondary (0-12) Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any liury or other treumatic event once. Be Barto Kraybill David Millar Kathryn ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Buskirk, P.O.A. 6910 Meadowlake Road, New Market, Maryland 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory Jul 14, 2006 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Reeney & Basford P.A. Funeral Home M00706 106 East Church St, Frederick, Maryland 21701 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** mante ma chtire /Medical resulting in death) Due to (or as a conequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 Z No 9 Unknown 9 Unknown been signed t should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. abptes nellitus 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? perten son has certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? ector. Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No Sign Director: After this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter To the Funeral Direct 4 - Homicide Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the (Check o Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. indhitte of certifier 29c. License number 29b. Signatu 29d. Date signed (Month, Day, Year) D51643 Shah I-Hron ims 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 honson Thomas 31. Date filed (Mor 32 Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year  $J_{u1v}^{\text{Mon}} 10,2006$ **Physician** 3:30pm CAROL STEVENSON MAOL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Civista Medical Center LaPlata Charles If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M XXF Yrs. 232-62-3919 67 Director SEPT. 20, 1938 W. V Usual Residence of Decedent r 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director WHITE PLAINS MARYLAND CHARLES 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? or items 23a or the Medical Examiner must be 4020 SPRING VALLEY DRIVE 20695 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X X X off Yes, Give Year or Dates: 1 ☐ Never Married XX Marned Maryland 21215-0036 1 Yes 2 No Specify: permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", c any highry or other traumatic event, the Medical Examples. à WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) OWN SELF MASTER BEAUTICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GLENNA ELIZABETH SMITH THOMAS HAROLD CRENSHAW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE BERT STEVENSON-SPOUSE 4020 SPRING VALLEY DR., WHITE PLAINS, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20695 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) TRINITY MEMORIAL GDNS 7-14-06 WALDORF, MARYLAND M00479 22. Name and Address of Facility 21. Signature of Funeral Service Licensee RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646.
Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications hat caused the death. shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy in the past 12 mon Month Day 4 Pregnant at time of death 5 Other (specify) r signed by the a P.O. 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Shoul 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s 2 No 1 Yes 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 TYes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 27. Manyer of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Matural 5 Pending М 1 Tes 2 No within 24 hours after death. To the Funaral Director: A 2 Accident investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide o the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or in estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 37174 100 N 30. Name a address of person who completed cause of death (Item 23a) (Type, Print) Song C. Chon, MD, Cenna Medical Center, 7C Post Office Rd., Waldorf, MD 20602 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 18 is speciel 2006 Registrar

DHMH 17 Rev 1/2001

Statenson

State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 1505 M Sarah Elizabeth Smith /Medical a. Facility Name (If not institution, give street and number Dorchester General) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Dorchester Cambridge If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, July 5, 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F Director 215-16-8037 1903 102 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits , or items 23s or 28s-f show 1 XYes 2 No Director Maryland Dorchester East New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death with 1 Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural, or itema 23a or 2 any injury or other traumatic avant, the Madical Examinational Lean once. 202 Railroad Avenue 21631 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Baltimore, Maryland 21215-0036 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) High School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Daniel Cookman Corkran Mary Eliza Corkran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Smith/Son 4715 Taylor Avenue, Hurlock, Maryland 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) East New Market Cemetery 7/6/2006 East New Market, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s certificete 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 V Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💆 No ၉ 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours efter deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 MD-2161 3 Mahbuba Akhter, M.D. AURORA 2006<sup>32, Reg</sup> 31. Date filed (Month, Day, Year) State 05 Registrar

**ORIGINAL** 

|                     |  | 1                | State of Maryland / Department of Health and M  1- For State Registrar Certificate of Death   |                                  | iene<br>og. No.                | 22680                                     |
|---------------------|--|------------------|---|----------------------------------|--------------------------------|---|
|                     |  |                  | Decedent's Name (First, Middle, Last)   | 2. Date of Deat                  | h                              | 3. Time of Death                          |
|                     | Physicia   |                  | Hazel Virginia Thurston   | Month                            | 4 Day 2006                     | 1135 AM                                   |
|                     | /Medić<br>Examin   |                  | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  | 1                                | 4c. County of Deat             | h   |
|                     | LXAIIIII   | SI.              | tAhrhey- heedy Nursing Home Boonsboro   | 9                                | Winding                        | raton                                     |
|                     | Funeral  |                  | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  | 8. Date of Birth<br>(Month, Day, | 9. Birt                        | hptace (State or Foreign units)           |
|                     | Director   |                  | 214-09-2878 1 Months Days Hours Min.  | 09/11/1                          |                                | MD  |
|                     | p  |                  | Usual Residence of Decedent   |                                  |                                |   |
|                     | rylar<br>thow  |                  | MD Washington Boonsboro   |                                  |                                | 10d. Inside City Limits<br>1 ☐ Yes 2 🔀 No |
|                     | e Ma   | cto              | MD Washington Boonsboro   |                                  |                                |   |
|                     | s 1 and 2 should be filed within 72 hours after death with the Maryland if Heath and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, Itel Medical Examinational be notified at | Funeral Director | 8507 Mapleville Road, Apt. 1103   | 1                                | 0g. Citizen of What Co<br>US   | untry?                                    |
|                     | ms 2   | nera             | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. Armed Forces? 15. Was Decedent of Hispanic Origin? (Sp. Armed Forces?) | ecify Yes or No-                 | 14. Race - Ame<br>Black, White |   |
| 9                   | or Ite   | 3                | 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☒ No Specify:  | nicari, etc.)                    | Specify:                       | White                                     |
| 8                   | rel', o  | ğ                | 3 Widowed 4 Divorced Year or Dates:   |                                  | Зреспу.                        | WILLCO                                    |
| 5-0                 | 72 h   | Completed        | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work)                    | ing                              | 16b. Kind of Business/         | Industry                                  |
| 2                   | ithin<br>nan<br>nan  | Idu              | Elementary/Secondary (0-12) College (1-4or 5+)  |                                  |                                | C   |
| 2                   | e filed within<br>al Hygiene.<br>I other then "<br>vent, Italie  |                  | 12 Assembler  17. Father's Name (First, Middle, Last) 18. Mother's Name   | - (Fire Minister )               | Aircra                         | III                                       |
| land                | ould be fii<br>Mental H<br>arkad ott   | To Be            |   | ınk) Stor                        |                                |   |
| Maryland 21215-0036 | d 2 should be<br>th and Mental<br>7 is marked<br>traumatic ev  |                  | 19a. Informant's Name/Relationship (Type, Print)  Preston W. Thurston / Husband  19b. Mailing Address (Street and Number or Rural Sold Mapleville Road,           |                                  |                                |   |
|                     | of Health a<br>of Health a<br>litam 27 ls<br>r other train   | 1                |   | -                                | 20c. Location - City or        |   |
| Ē                   | Pages<br>nent of<br>ant: If it,<br>ury or o  |                  | Rose Hill Cemetery 07/07  | 7/2006 I                         | Hagerstown,                    | , MD                                      |
| Baltimore,          | permit. Pages<br>Department of<br>Important: If if<br>any injury or o  |                  |   |                                  |                                | neral Home                                |
|                     |  |                  | 305 N. Potomac Str  |                                  |                                | Approximate                               |
|                     |  |                  | shock, or heart failure. List only one cause on each line. Immediate Cause (Final   |                                  |                                | Interval Between<br>Onset and Death       |
|                     | Physician<br>/Medical  |                  | disease or condition resulting in death)  |                                  |                                |   |
|                     | Examiner   |                  | Due to (or as a consequence of):  Atrial FibriNation  |                                  |                                |   |
|                     |  | -                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):   |                                  |                                |   |
|                     | ted<br>nsit  | nin              | cause. Enter Underlying Cause (Disease or injury that initiated events  c   |                                  |                                |   |
| -                   | cate be executed oblysician and the burial-transit   | Examiner         | resulting in death) Last  |                                  |                                |   |
| 8760,               | be e   |                  |   |                                  |                                |   |
| 687                 | cate<br>ohy:   | edical           | d   |                                  |                                |   |
|                     | The law requires that the death certific to has been signed by the attending prage 2 should be detached for use as   | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy   |                                  | 23d. Date of del               | ivery                                     |
| Вох                 | atter<br>for u   | ciar             | in the past 12 months?  |                                  | Month                          | Day Year                                  |
| O.                  | the d<br>y the   | iysi             | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  |                                  |                                |   |
| Ω.                  | that the de<br>led by the a<br>detached  |                  | Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  | 23e. Did tot                     | pacco use contribute to        | the cause of death?                       |
| sp                  | uires<br>sign<br>d be  | d by             | Dementiq  | 1 □ Ye                           | es 2□No 3□Pr                   | obably 4 Unknown                          |
| Records,            | w require<br>been sig<br>should b  | Completed        | malnutrition  | 24a. Was a                       | n 24b. Were au                 | topsy findings available                  |
| Re                  | has<br>ge 2  | mp               | MAINMAIN  | autops                           | y prior to o death?            | completion of cause of                    |
| a                   |  |                  |   |                                  |                                | 2 □ No                                    |
| Vital               | Physician:<br>this certific<br>ral director,   | o Be             | 25. Was case referred to medical examiner?  1   Yes 2   No  |                                  | e)<br>ence 6 □Other (Spe       | -40                                       |
| of                  |  | <b>-</b>         | To res 22 No Tompatient 2 Produpatient 3 DOA 4 Profising no   |                                  | ow injury occurred             | cny)                                      |
| no                  | ding F<br>h.<br>After<br>funer   | tlon             | 27. Manner of Death  1. Natural 5 Pending (Month, Day Year)  2. Accident investigation M 2. Security Work?  2. Accident investigation M M 1 Year                  |                                  |                                |   |
| isi                 | or Attanding<br>after death.<br>Diractor: After<br>in by the fune  | lica             | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office  | 28f. Location (St                | reet and Number or Ru          | ıral Route Number,                        |
| Division            | or Attand<br>after death<br>Diractor: /  | Certification:   | 4 Homicide determined building, etc. (Specify)  | City or Town                     | n, State)                      |   |
| _                   | spita<br>nours<br>naral  |                  | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,   |                                  |                                |   |
|                     | To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by   | edical           | (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence)  |                                  |                                |   |
|                     | ro th<br>Mithir<br>Fo th   | Me               | 29b. Signature and title of certifier 29c. License number   |                                  | 9d. Date signed (Monti         |   |
|                     |  |                  | Jame muched 0060396   |                                  | 07/05                          | 06  |
|                     |  |                  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  | et                               |                                |   |
| sit                 | 4-5  |                  | FARID MURSHED MO  | rstour                           | MD 2                           | 1740                                      |
|                     | Sta  | ate              | 31. Date filed (Month, Day, Year) 6 2006 32. Redistrar's Signature B. Sparke  |                                  | )                              |   |
| * -                 | Regist   | rar              | JUL U & 2000 Brew B. Spulle   |                                  |                                |   |

DHMH 17 Rev 1/2001

Thurston, URZEL

|                                |  | •               | 1 - State<br>Registrate PEND#18perFH7/3  | State of Ma<br>/06,EMW,Mod                |                 |                          |                        |                                       | ealth a<br>Death | and M        |  | giene<br>Reg. No | 71116                             | 22681   |
|--------------------------------|--|-----------------|--|---|-----------------|--------------------------|------------------------|---------------------------------------|------------------|--------------|--|------------------|-----------------------------------|---|
|                                | 4  |                 | 1. Decedent's Name (First, Middle, Last)   |   |                 |                          |                        | -                                     |                  |              | 2. Date of Dea                                 | ath<br>Da        | v Year                            | 3. Time of Death                              |
|                                | Physicia<br>/Medic   |                 | DOWLAT_TAIMORI   |   |                 |                          |                        |                                       |                  |              | JUNE 29  |                  |                                   | 5:30 P M                                      |
| ŀ                              | Examin   | -               | 4a. Facility Name (If not institution, give s                                    | treet and number)                         |                 |                          | 4b. City,              | Town, or                              | Location o       | of Death     |  | 4c.              | . County of Death                 |   |
|                                |  |                 | ADVENTIST HEALTH CA  |   |                 |                          |                        |                                       | IA PARK          |              |  |                  | MONTGOMERY                        |   |
|                                | Funeral  |                 | 5. Social Security Number 6. Sex   | 7. Ag<br>M 2⊠F                            |                 | ast birthday)<br>Yrs.    | Months Months          | r 1 Year<br>Days                      | Hours            | Min.         | <ol><li>Date of Birt<br/>(Month, Day</li></ol> | y, Year)         | Cou                               | place (State or Foreign<br>ntry)              |
| ā                              | Director   |                 | 578-76-7985 Usuat Residence of Decedent  |   | 86              | 115.                     |                        |                                       |                  |              | SEPTEMBER                                      | ₹ 10,            | 1919                              | INDIA   |
|                                | land w   |                 | 10a. State 10b. County   |   | 10c. City       | , Town or Lo             | cation                 |                                       |                  |              |  |                  |                                   | 10d. toside City Limits                       |
|                                | Mary<br>I sh   | ţ               | MARYLAND PRINCE GEO  | RGES                                      |                 | HYA'                     | TTSVII                 | LE.                                   |                  |              |  |                  |                                   | 1 ☐ Yes 2 🖾 No                                |
|                                | r 28e  | Director        | 10e. Street and Number   |   |                 |                          | 10f. Zip               |                                       |                  |              |  | 10g. Cit         | tizen of What Cou                 | ntry?   |
|                                | h witi   | a D             | 1800 DREXEL STREET #20   | 1   |                 |                          |                        |                                       | 20783            |              |  |                  | U.S.A.                            |   |
|                                | deat   | Funeral         | 11. Marital Status   | 2. Was Decedent<br>Armed Forces?          |                 | S. 13. \                 | Nas Dece               | dent of His                           | spanic Orig      | gin? (Spe    | cify Yes or No-<br>Rican, etc.)                | -                | 14. Race - Ameri<br>Black, White, |   |
| 9                              | after<br>or Its  | 교               | 1 Never Married 2 Married  | 1 ☐ Yes 2 🔯                               |                 |                          |                        |                                       | Specify:         | , 1 46110 1  | ilicari, etc.)                                 |                  |                                   |   |
| ğ                              | be filed within 72 hours after death with the Maryland Ital Hyglene. I have seen them "see" show to other then "netural", or items 23e or 28e-f show event, the Medical Examinat must be notified at | d by            | 3 X Widowed 4 □ Divorced   | Year or Dates:                            |                 |                          |                        |                                       | - 30             |              |  |                  |                                   | SIAN  |
| Ÿ                              | "nat   | Completed       | 15. Decedent's Educ<br>(Specify only highest grade                               |   |                 | 16a. Deced               | kind of wo             | al Occupa<br>ork done d<br>se retired | uring most       | t of working | ng   | 16b. K           | (ind of Business/Ir               | ndustry                                       |
| 2                              | withi<br>ene.<br>then  | m d             | Elementary/Secondary (0-12)  | College (1-4or !                          | 5+)             |                          |                        | SECRI                                 |                  |              |  |                  | PRIVATE                           |   |
| 0                              | filed w<br>Hygier<br>other th  |                 | 17. Father's Name (First, Middle, Last)  |   |                 |                          | DEGAL                  | ) DECIG                               |                  | r's Name     | (First, Middle<br>1. Iran                      | Maiden           |                                   | -   |
| <u>a</u>                       | ld be<br>ental<br>ked c  | To Be           | TIRENDAZ H. IRANI  |   |                 |                          |                        |                                       | Jer              |              | RANI   | I I              |                                   |   |
| ary                            | 2 should be filed<br>and Mental Hygis<br>Is marked other<br>aumatic event,   | -               | 19a. Informant's Name/Relationship (Typ  | oe, Print)                                |                 | 19b. Mailir              | g Address              | s (Street a                           | nd Numbe         | r or Aurai   | Route Numbe                                    | er, City o       | or Town, State, Zij               | o Code)                                       |
| Ž                              | permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 is marke any injury or other traumatic:  | 1 8             | LYNN NICHOLAS - PERSON   | AL REP.                                   |                 | 7207                     | TRESCO                 | TT AVI                                | ENUE.            | TAKOMA       | A PARK, M                                      | 1ARYL            | AND 20912                         |   |
| Baltimore, Maryland 21215-0036 | of He of He roth   |                 | 20a. Method of Disposition   |   | 20b. P          | lace of Dispo            | sition (Na.            | me of                                 |                  |              | ate  |                  | ocation - City or T               | own, State                                    |
| Ĕ                              | Pages<br>nent of<br>ant: If its  |                 | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)              | emoval from State                         | ŀ               | JDON PAR                 |                        |                                       |                  | 7/1/2        | 006  | BALT             | TIMORE, MAR                       | RYLAND  |
| a                              | Department Important: sny injury once.   |                 | 21. Signature of Funeral Service License   | е /                                       |                 | 22                       | . Name a               | nd Addres                             | s of Facilit     | y HIN        | NES-RINAL                                      |                  | UNERAL HOM                        |   |
| <b>m</b>                       | 825 2 8  | V. 3            | Towns N  | Slend                                     | حملا            |                          | 11800                  | NEW H                                 | AMPSHI           |              |  |                  |                                   | RYLAND 20904                                  |
|                                |  |                 | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on | cations that caused<br>e cause on each li | d the death     | n. Do not ent            | er the mod             | de of dying                           | g, such as       | cardiac oi   | respiratory ar                                 | rest,            |                                   | Approximate<br>Interval Between               |
|                                | Physician  |                 | Immediate Cause (Final disease or condition                                      | Met                                       | 2 St.           | sh'C                     | Sa                     | ha                                    | mon              | 1            | Cel)   | 0                | anew                              | Onset and Death                               |
|                                | /Medical<br>Examiner   |                 | resulting in death)  | Due to (or as                             | a consequ       | uence of):               | 1                      | /                                     | 1                | - 1          |  |                  |                                   |   |
| П                              | Lxammer  | _               | Sequentially list conditions b   |   | 12              | es hi                    | Ight                   | 4                                     | 12               | 4/4          | ve   |                  |                                   |   |
|                                | ed sslt  | lhe             | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury    | Due to (or as                             | a consequ       | ience of :               |                        | 0                                     |                  |              |  |                  |                                   |   |
|                                | The law requires thet the death certificate be executed ase hes been signed by the attending physician and bage 2 should be detached for use as the burial-transit                                   | Examiner        | that initiated events cresulting in death) Last                                  | Due to (or as                             | a consequ       | uence of):               | _                      |                                       |                  |              |  |                  |                                   |   |
| 8760                           | sician<br>buris  | dical E         |  | _   |                 |                          |                        |                                       |                  |              |  |                  |                                   |   |
| 687                            | ficate<br>p physics the  | edic            |  |   |                 |                          |                        |                                       |                  |              |  |                  |                                   |   |
| Box                            | n certi  | N               | IF FEMALE: 23b. Was decedent pregnant  | 3c. If yes, outcome                       |                 |                          |                        |                                       |                  |              |  |                  | 23d. Date of deliv                | ery   |
| ň                              | death<br>e atte<br>d for   | Icla            | in the past 12 months?<br>1 ☐ Yes 2 ☑ No   | 1 ☐ Live birth<br>4 ☐ Pregnant a          |                 |                          | Ectopic p<br>Other (s) |                                       |                  |              |  |                  | Month                             | Day Year                                      |
| P.<br>O.                       | thet the de<br>ned by the a  | hys             | 9 🗌 Unknown  | 9 Unknown                                 |                 |                          |                        |                                       |                  |              |  |                  |                                   |   |
|                                | signed<br>be del   | by Physician/Me | Part II. Other significant conditions con  | tributing to death b                      | out not resu    | ulti <b>n</b> g in the u | nderlying o            | ause give                             | n in Part I.     |              | 23e. Did to                                    | obacco (         | use contribute to t               | he cause of death?                            |
| ğ                              | w require<br>been si<br>should t   |                 |  |   |                 |                          |                        |                                       |                  |              | 101  | res 2            | □No 3□Prol                        | bably 4 Tunknown                              |
| Division of Vital Records,     | law re<br>Bs be<br>2 she   | Completed       |  |   |                 |                          |                        |                                       |                  |              | 24a. Was                                       |                  | 24b. Were auto                    | opsy findings available empletion of cause of |
| Œ                              | The<br>ete h<br>page   | E C             |  |   |                 |                          |                        |                                       |                  |              | perfor   | rmed?            | death?                            |   |
| <u>i</u>                       | clan:<br>ertific   | Be (            | 25. Was case referred to medical examiner?                                       |   |                 |                          |                        |                                       | 26. Ptace        | of Death     | (Check only o                                  | ne)              |                                   |   |
| $\leq$                         | hyslo<br>this co   | 2               | 1 ☐ Yes 2 ☐ No H   | ospital: 1 🔲 Inpatio                      |                 | ER/Outpatien             |                        |                                       | 4 2 190          |              |  |                  | 6 ☐Other (Special                 | fy)   |
| Ē                              | ing P  | ë               | 27. Manner of Death 1 ☐Natural 5 ☐ Pending                                       | 28a. Date of Inju<br>(Month, Da           | iry<br>iy Year) | 28b. Time of<br>Injury   |                        | 28c. Injury<br>Work                   |                  |              | 8d. Describe h                                 | now inju         | ry occurred                       |   |
| S                              | Attending Physician: or death. ector: After this certifice by the funeral director, g  | cat             | 2 Accident investigation 3 Suicide 6 Could not be                                | One Place of In                           | ium. Asha       | 1                        | М                      |                                       | /es 2 □ I        |              | 106 Legation /6                                | 24               |                                   | -/  |
| $\leq$                         | l or A<br>effer<br>Direction by  | Certification:  | 4 Homicide determined  | 28e. Place of In<br>building, et          | tc. (Specify    | me, tarm, str            | eet, ractor            | у, опісе                              |                  | -            | City or Tou                                    | vn, State        | nd Number or Run<br>e)            | ai Houte Number,                              |
| _                              | To the Hospital or Attending Physician: The law within 24 hours efter death.  To the Funeral Director: After this certificete hes completely filled in by the funeral director, page 2               |                 | 29a. Certifier 1 Certifying Phys   | icien: To the best                        | of my kno       | wledge death             | OCCUITE                | Lat the tim                           | e date an        | d place a    | ind due to the                                 | cause/e          | ) and manner as s                 | chatch  |
|                                | 24 h<br>24 h<br>Fur<br>etely   | edical          | (Check only 2 Medical Exeminate)   | ner: On the basis of<br>and manner st     | of examinat     | tion and/or in           | vestigation            | n, in my op                           | oinion, dea      | th occurre   | d at the time,                                 | date and         | d place, and due t                | to the cause(s)                               |
|                                | rothin<br>Fothin   | Me              | 29b. Signature and title of certifier  |   |                 |                          | 29                     | c. License                            |                  |              |  |                  | ite signed (Month,                |   |
|                                | 0  |                 | <ul><li>4</li></ul>  | MI  | )               |                          |                        | 00                                    | 06               | 010          | U  | 06               | -290                              | 6   |
|                                | V  |                 | 30. Name and address of person who co  | mpleted cause of                          | death (Item     | 23a) (Type,              | Print)                 |                                       |                  |              |  |                  |                                   |   |
|                                |  |                 | TAGMINA  | 16  | AG              | tou E                    | p 7252                 | CARR                                  | OLL AV           | EENUE        | TAKOMA I                                       | PARK,            | MARYLAND                          |   |
|                                | Sta  |                 | 31. Date filed (Month, Day, Year)  | 32. degisti                               | rar's Signa     | ture do                  | a. M                   | )                                     |                  |              |  |                  |                                   |   |
|                                | Registi  | ar              | JUL 0 3 20   | 06 AR.                                    |                 | To #10                   |                        |                                       |                  |              |  |                  |                                   |   |

|                               |  |                                     | For<br>State<br>Registrar  | State of Marylan  |  | artment of   |   |  | giene                                 | 6 22682  |
|-------------------------------|--|-------------------------------------|--|---|--|--|---|--|---------------------------------------|--|
| -                             | Physicia<br>/Medio<br>Examin   | al                                  | 1. Decedent's Name (First, Middle, Last Company of the Company of  | street and number)  | tal  | Tho. 4b. City, Town  | mp Son n, of Location of Dea  | 2. Date of Dea<br>Month<br>JUNE  |                                       |  |
|                               | Funeral<br>Director  |                                     | 5. Social Security Number 6. Se  | 7. Age (In)yrs.   | last birthday)<br>Yrs.   | If Under 1 Ye Months Da  | ar If Under 24 Hrs  | 8. Date of Birt<br>Month, Day<br>Jan 22  | y, Year) 9. Bir<br>, 1953 Was         | thplace (State or Foreign outly)<br>Shington, D(                                     |
| altimore, Maryland 21215-0036 | nit. Pages 1 and 2 should be filed within 72 hours elter death with the Maryland artment of Health and Meniel Hygiene. ortant: if item 27 is marked other the "naturel", or iteme 23a or 28e-f ehow injury or other traumatic event, the Madical Examinar must be rediffied at injury or other traumatic event, the Madical Examinar must be rediffied at a.   | To Be Completed by Funeral Director | Usual Hesidence of Decedent  10a. State  10b. County  MD  Charl  10e. Street and Number  11931 Knollcre  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  (Specify only highest grace  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)  George Connell  19a. Informant's Name/Relationship (7)  Mary Jo Thomps  20a. Method of Disposition  1 Burial 2 Cremation 3 II 4 Donation 5 Other (Specify  21. Signature of Funegal Service Licens  | St Lane  12. Was Decedent Ever in U. Amed Forces? 1 MYes 2 Decedent Ever in U. Amed Forces? 1 MYes 2 Decedent Ever in U. Amed Forces? 1 MYes 2 Decedent Ever in U. Amed Forces? 1 MYes 2 Decedent Ever in U. Amed Forces? 1 MYes 2 Decedent Ever in U. Amed Forces? 1 MYes 2 Decedent Ever in U. Amed Forces? 1 MYes Completed (1-4or 5+)  Thompson, 20b. P. Composition of Composition State (Recompleted)  Removat from State (Recompleted) | S. 13. \ 16a. Decec (Give life.   Equ   Sr. 19b. Mailir   1193   lace of Dispoemeter, crer surre | Plata  10f. Zip Cod  20  Was Decedent of Yes, specify Cod  in Yes 2 Mill  dent's Usuat Ockind of work do  DO NOT use re  lipmen  ag Address (Str.  knol  sition (Name or matory or other)  ction | of Hispanic Origin? (Suban, Mexican, Pue No Specify:  cupation meduring most of we tired)  18. Mother's Na Jeanet  lcrest L  place) 7-3- Cemetery | Specify Yes or No- roo Rican, etc.)  orking  T  the Daws  fural Route Numbe  n. La P  O 6  7 | Canaiha                               | erican Indian, te, etc.  Lite  Undustry  Lotion  L1  Zip Code) 20646 Town, State  MD |
| 8760,                         | Centificate be executed  Physician and framel transit  Centificate but and transit transit  Physician and transit tran | Ical Examiner                       | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of the time disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a. Sep 5/3 Due to (of as a conseq   | Suence of): 2045 uence of): toge   | er the mode of   | Box 567<br>dying, such as cardia<br>cial Pe   | c or respiratory an  | rest.                                 | Approximate Interval Between Onset and Death 2 days  8 days  6 years                 |
| P.O. Box 68                   | death<br>e atter   | by Physician/Medi                   | tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown   | 23c. If yes, outcome of pregna<br>1 □ Live birth 2 □ Feta<br>4 □ Pregnant at time of d<br>9 □ Unknown   | Ideath 3□  | ⊒Ectopic pregna<br>] Other <i>(specify</i>   |   |  | 23d. Date of de<br>Month              | livery<br>Day Year   |
| Division of Vital Records, F  | The law requi  | Completed by P                      | Part II. Other significant conditions co   | ntributing to death but not res   | ulting in the u  | nderlying cause  | given in Part I.  | 1 🗆 Y  | an 24b. Were a                        | utopsy findings available completion of cause of                                     |
| on of Vita                    | Attending Physicien: The law r death. c death. ector: After this certificete hes by the funeral director, page 2 s   | To Be                               | 27. Manner of Death  1 Natural 5 Pending   | Hospitat: 1 Inpatient 2 Inpatient 2 (Month, Day Year)   | ER/Outpatier<br>28b. Time of<br>Injury   | 28c. [   | Othor   | eath (Check only o   |                                       |  |
| Divisi                        | The tree   | Certification:                      | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury - At h<br>building, etc. (Specif   | ome, farm, str   |  |   | 28f. Location (S<br>City or Tow  | Street and Number or Fi<br>vn, State) | ural Route Number,   |
|                               | To the Hospital of within 24 hours all To the Funerel D completely filled it   | Medical                             | (Check only 2 Medical Exam   | rsician: To the best of my knotiner: On the basis of examina and manner stated.   | ition and/or in  | vestigation, in n  | ny opinion, death occ   | curred at the time,  | date and place, and du                | e to the cause(s)  |
| )                             | F 3 F 8  |                                     | 30. Name and address of person who o   | ompleted cause of death (Item   | n 23a) (Type,  | R E  | 5-00  | 0  | June 2°                               | 7,2006   |
|                               | Sta<br>Registr   |                                     | 29b. Signature and title of certifier  30. Name and address of person who continued to the series of person who continued to the series of person who continued to the series of person who continued to the series of person who continued to the series of person who continued to the series of the s | 32. Agistrar's Signa<br>2006  | tal 600  | North W  | lolfe Stree   | t, 13altim   | ore, Maryla                           | nd 21287   |

|             |   | -                | 1 - State of Maryland / I  | Department of Health and N<br>Certificate of Death   | Mental Hygiene 2 0   | 06 22683   |
|-------------|---|------------------|--|--|--|--|
|             | Physicia<br>/Medic  |                  | Decedent's Name (First, Middle, Last)     Raymond Earl Taylor  |  | June 28, 2006  | 3. Time of Death 7:25 A M  |
| }           | Examin Funeral Director   | er               | 4a. Facility Name (If not institution, give street and number)  Southern Maryland Hospital  5. Social Security Number  6. Sex 1 (XM 2   F 59)  7. Age (In yrs. last bit)   | 4b. City, Town, or Location of Death Clinton  thday) Yrs.  4b. City, Town, or Location of Death Clinton  If Under 1 Year   If Under 24 Hrs. Months   Days   Hours   Min. |  | y of Death  ICE George's  9. Birthplace (State or Foreign Country)  Washington, DC |
|             | ס   |                  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow   | n or Location  Heights   |  | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No   |
|             | with the M<br>3a or 28a-f<br>it be notifits   | Funeral Director | 10e. Street and Number 120 Mohican Drive   | 101. Zip Code<br>20745   | 10g. Citizen of USA  | What Country?  |
| 336         | 72 hours after death with the Maryland<br>natural; or Items 23s or 28s-f ehow<br>deat Examiner must be notified at  | þ                | 11. Marital Status  1 Never Married 2 Marned  3 Widowed 4 Dovorced  12. Was Decedent Ever in U.S. Armed Forces?  1027es 2 No 1966—  11 Yes, Give Year or Dates:  | 13. Was Decedent of Hispanic Origin? (S<br>If Yes, specify Cuban, Mexican, Puerton<br>1 Yes 2 No Specify:  |  | ce - American Indian,<br>ck, White, etc.<br>iy: White                              |
| 21215-0036  | within<br>ene.<br>than  | Completed        | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Coltege (1-4or 5+)   | Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Foreman  | king   | usiness/Industry<br>7 Store Bakery   |
| Maryland 2  | o la b  | To Be C          | 17. Father's Name (First, Middle, Last)  Raymond Farl Taylor Jr.   |  | ne (First, Middle, Maiden Sumar<br>Bell Lockard            | ne)  |
|             | nd 2 allth ar   |                  | Bonnie King / Daughter 12  | o. Mailing Address (Street and Number or Ru<br>20 Mohican Drive Forest H   | eights, Maryland   | 20745  |
| Baltimore,  | Page<br>nent o<br>ant: If<br>ury or   |                  | 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Kalas  |  | , 2,2006 Edgewa  |  |
| Balt        | permit. Pag<br>Department<br>Important: I<br>any injury o   |                  | 21. Signature of Funeral Service Licensee  23a. Part 1. Enter the disease, or complications that caused the death. Do  | rge P. Kalas Funera<br>Oxon Hill, Maryland   |  |  |
| 8760,       | hysician be executed / Medical Examiner and is the burial-transit   | edical Examiner  | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conditions) of the conditions of the c | tory Theres  | as is  | Interval Between<br>Onset and Death  |
| P.O. Box 6  | death certi<br>e attending<br>id for use a  | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death  | h 3 Ectopic pregnancy 5 Other (specify)  |  | ate of delivery<br>onth Day Year   |
|             | 8 P 8   | 5                | Part II. Other significant conditions contributing to death but not resulting  | in the underlying cause given in Part I.   | 23e. Did tobacco use con                                   | atribute to the cause of death?  3 □ Probably ※XXVnknown                           |
| il Records, | > 0 0   | Completed        |  |  | 24a. Was an autopsy performed? 1 Yes 2 No                  | Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No |
| Vital       | Physician:<br>r this certific<br>ral director,  | Be               | 25. Was case referred to medical examiner?  Hospital:  | Other  | ath (Check only one)                                       |  |
| ō           | To the Hospitel or Attending Physicien: The law within 24 hours effer death. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2 | tlon: To         | 1 Tes 2 VINO 1 Mainpatient 2 EH/C  | Unpatient 3  | lome 5 ☐ Residence 6 ☐ Ot<br>28d. Describe how injury occu |  |
| Division    | Itel or Atten<br>is efter deal<br>ral Director:<br>led in by the  | Certification:   | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)   | farm, street, factory, office  | 28t. Location (Street and Num<br>City or Town, State)      | ber or Rural Route Number,   |
|             | ne Hospite<br>n 24 hours<br>ne Funera   | Medical C        | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge of the basis of examination and manner stated.  |  |  |  |
|             | To th<br>To th<br>comp  | Ň                | 29b. Signature and utile of certifier  | 29c. License number D004158  |  | ed (Month, Day, Year)  |
| R           | (3) 1k  | ì                | 30. Name and address of ears who completed cause of death (Item 23a Scott Kelso Md 7503 Surratts   | (Type, Print)  Road Clinton, Maryl:  | and 20735  |  |
|             | St<br>Regist  | ate<br>rar       | 31. Date filed (Month, Day, Year) 2. Registrar's Signature   | books  |  |  |

22684

State of Maryland / Department of Health and Mental Hygiene

|                     |  |                | - State<br>Registrar  |                                      |                                   |                                   | Cert          | ificat                  | e of L                   | Death  |                            |                        | Reg                    | . No.                    |                             |   |
|---------------------|--|----------------|---|--------------------------------------|-----------------------------------|-----------------------------------|---------------|-------------------------|--------------------------|--|----------------------------|------------------------|------------------------|--------------------------|-----------------------------|---|
|                     |  |                | 1. Decedent's Name (First, Middle   | e, Last)                             |                                   |                                   |               |                         |                          |  |                            | 2. Date<br>Mont        | of Death               | Day                      | Year                        | 3. Time of Death                            |
|                     | Physicia<br>/Medic   |                | LOIS  | PAIR                                 | TUR                               | NER                               |               |                         |                          |  |                            |                        |                        | ,2006                    | real                        | 10:15A. <sup>M</sup>                        |
|                     | Examin   |                | 4a. Fecility Name (If not institution   | n, give street and i                 | nu <i>mber)</i>                   |                                   |               | 4b. City,               | Town, or                 | Location   | of Death                   |                        |                        | 4c. Coun                 | ty of Death                 |   |
|                     |  |                | ARDEN COURT A   | SST. LIV                             | ING                               |                                   |               | SI                      | LVER                     | SPRI   | NG                         |                        |                        | MON'                     | TGOME                       | RY  |
|                     | Funeral  |                | 5. Social Security Number   | 6. Sex<br>1 ☐ M 2 ☐ XF               |                                   | e (In yrs. last biri<br>98        |               | If Under<br>Months      |                          | If Under<br>Hours  | 24 Hrs.<br>Min.            | 8. Date<br>(Mon        | of Birth<br>th, Day, Y | (ear)                    | 9. Birth                    | place (State or Foreign ntry)               |
|                     | Director   |                | 578 62 2222   | 1 L M 2 LAN-                         |                                   | 90                                | Yrs.          |                         | ,_                       |  |                            | 6/1                    | 2/19                   | 08                       | WASH                        | .,D.C                                       |
|                     | and W  |                | Usual Residence of Decedent  10a, State  10b, County  | ,                                    |                                   | 10c. City, Town                   | or Loca       | ation                   |                          |  |                            |                        |                        |                          |                             | 10d. Inside City Limits                     |
|                     | lanyli<br>sho  | ក              | D.C.  |                                      |                                   | WASHIN                            |               |                         | .с.                      |  |                            |                        |                        |                          |                             | 1 X Yes 2 □ No                              |
|                     | 28a-   | Director       | 10e. Street and Number  |                                      |                                   |                                   |               | 10f. Zip                |                          |  |                            |                        | 100                    | . Citizen of             | f What Cou                  | ntn/2                                       |
|                     | with   |                | 7835 16th ST  | .,N.W.                               |                                   |                                   |               | TOIL EID                |                          | 20012  | 2                          |                        | .00                    | US                       |                             |   |
|                     | within 72 hours aftar death with the Maryland<br>ane.<br>then "netural", or Items 23e or 28e-f show<br>in Medicel Exercites must be notified at  | Funerai        | 11. Marital Status  | 12. Was D                            | ecedent                           | Ever in U.S.                      | 13. W         | as Deced                | dent of Hi               | spanic Or  | igin? (Spe                 | ecify Yes              | or No-                 | 14. Ra                   | ace - Ameri                 | can Indian.                                 |
| ^                   | ftar o   | F              | 1 Never Married 2 Mar   | ried 1 ☐ Ye                          | Forces?                           | No                                |               |                         |                          | spanic Or<br>n, Mexicai  |                            | Rican, et              | c.)                    | Bi                       | ack, White,                 | etc.  |
| ž                   | urs a  | by             | 3 X Widowed 4 □ Divorced  | If Yes,<br>Year o                    | Give<br>r Dates:                  |                                   | 1[            | ☐ Yes                   | 2 🔀 No                   | Specify:   |                            |                        |                        | Spec                     | ity: BLA                    | CK  |
| Maryland 21215-0036 | 72 ho  | Completed      | 15. Deceder<br>(Specify only highe  | nt's Education                       | d)                                | 16a.                              | Decede        | int's Usua              | al Occupa                | ation  | t of worki                 | na                     | 16                     | b. Kind of I             | Business/In                 | dustry                                      |
| 21                  | ba filad within 72 hc<br>tal Hygiana.<br>d othar than "natur<br>event, tra Predical  | npie           | Elementary/Secondary (0-12)   |                                      | (1-4or 5                          |                                   |               |                         | se retired               | turing mos   | I OI HOIKI                 | rig                    | ח                      | C PI                     | IIRT TC                     | SCHOOLS                                     |
| 7                   | filad wi<br>Hygian<br>othar th   | Con            | 12  | 5+                                   |                                   | 1                                 | EACI          | HER                     |                          |  |                            |                        |                        |                          |                             |   |
|                     | al Hy<br>d oth   | Be             | 17. Father's Name (First, Middle,   |                                      |                                   |                                   |               |                         |                          |  |                            |                        |                        | iden Suma                | ame)                        |   |
| <u>X</u>            |  | ပ              | REV. JAMES  |                                      |                                   |                                   |               |                         |                          |  | ILA T                      |                        |                        |                          |                             |   |
| ā                   | 2  |                | 19a. Informant's Name/Relations LOIS T. HOPSO   |                                      | משתנ                              |                                   |               |                         |                          |  |                            |                        |                        | City or Town 20012       | n, State, Zip               | Code)                                       |
|                     | C - C -  |                |   |                                      | .111.                             | 20b. Place of                     |               |                         |                          | , IV . W .   |                            | ate                    |                        |                          | O: T                        |   |
| 0                   | d 0  |                | 20a. Method of Disposition 1 ☐ Purial 2 ☐ Cremation   |                                      | m State                           | cemeter                           | y, crema      | atory or o              | ther plac                | e)   |                            |                        |                        | c. Location              | -                           |   |
| E                   | t. Pa<br>tman<br>tant:   |                | `4 □Donation 5 □Other (S  |                                      | -                                 | LINCO                             |               |                         |                          |  | 6/29                       |                        |                        | SUITL                    | •                           |   |
| Baltimore,          | parmit. Page<br>Departmant<br>Important: Il<br>any Injury o  |                | 21. Signature of Funeral Service  | Urcensee (                           | 1/1                               |                                   | 22.           | Name an                 | id Addres                | s of Facili  | by JOH                     | NT.                    | RHI                    | NES FI                   | UNERA                       | L HOME                                      |
|                     | 40144  |                | 12a Part Satar the diagram  | mile                                 |                                   | Litha dooth Do                    |               |                         |                          |  |                            |                        |                        | .C. 20                   | 0017                        | Approximate                                 |
|                     |  |                | 23a. Pirt1. Enter the disease, o slock, or heart failure. Lis                                       | only one cause o                     |                                   |                                   |               |                         | e or dynn                | y, such as   | cardiaco                   | пезрпа                 | tory arres             | ι,                       |                             | Interval Between<br>Onset and Death         |
|                     | Physician /Medical   |                | Immediate Cause (Final disease or condition resulting in death)                                     | a                                    |                                   | VANCED D                          |               | NITA                    |                          |  |                            |                        |                        |                          |                             |   |
| Н                   | Examiner   |                | •   | Due                                  |                                   | a consequence RONIC OF            |               | ICTT                    | VE PI                    | III.MON  | IARY '                     | DISE                   | ASE                    |                          |                             |   |
|                     |  | -              | Sequentially list conditions,   | b. Due                               |                                   | а сопъециелсе                     |               |                         |                          |  |                            | - 101                  |                        |                          | -                           |   |
|                     | tad<br>nsit  | 듣              | ti any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | <                                    |                                   | NGESTIVE                          |               | ART I                   | FAIL                     | URE  |                            |                        |                        |                          |                             |   |
|                     | axacu<br>n and<br>al-tra   | Examiner       | that initiated events<br>resulting in death) Last   | c. Due                               |                                   | a consequence                     |               |                         |                          |  |                            |                        |                        |                          |                             |   |
| 68760,              | sicia<br>sicia   |                |   | d                                    | 0                                 | STEOPORC                          | SIS           |                         |                          |  |                            |                        |                        |                          |                             |   |
|                     | laath cartificata ba axacutad<br>attanding physician and<br>I for usa as the burial-transit  | n/Medical      |   |                                      |                                   |                                   |               |                         |                          |  |                            |                        |                        |                          |                             |   |
| ŏ                   | n carl<br>andin<br>usa   |                | IF FEMALE:<br>23b. Was decedent pregnant  |                                      |                                   | of pregnancy                      | 2 □           | -<br>-<br>-             |                          |  |                            |                        |                        | 23d. D                   | ate of deliv                | ery   |
| m                   | daati  | icia           | in the past 12 months?<br>1 □ Yes 2 XNo   |                                      | egnant at                         | 2 ☐ Fetal death<br>time of death  |               | Ectopic pr<br>Other (sp |                          |  |                            |                        |                        | N                        | fonth                       | Day Year                                    |
| <u>о</u>            | Tha law raquiras that tha daeth<br>ata has bean signad by the attar<br>cage 2 should ba datached for u   | by Physicia    | 9 Unknown   | 90.01                                | Known                             |                                   |               |                         |                          |  |                            |                        |                        |                          |                             |   |
|                     | as tha<br>gnad<br>oa da  | by F           | Part II. Other significant conditi<br>OSTEOARTH   | •                                    | death b                           | ut not resulting in               | the unc       | derlying c              | ause give                | en in Part I   | i.                         | 23e.                   | Did toba               | cco use cor              |                             | he cause of death?                          |
| Records,            | w raquira<br>bean si<br>should b   |                | OSIEUAKIH   | KIIIS                                |                                   |                                   |               |                         |                          |  |                            |                        | 1 🗌 Yes                | 2 🗆 No                   | 3 ☐ Prot                    | pably X Unknown                             |
| ၁၁                  | a law ra<br>has be<br>je 2 sh  | pie            |   |                                      |                                   |                                   |               |                         |                          |  |                            | 24a.                   | Was an autopsy         | 24b                      | . Were auto                 | psy findings available mpletion of cause of |
|                     |  | Completed      |   |                                      |                                   |                                   |               |                         |                          |  |                            | 10                     | performe               | id?<br>No                | death?                      | X No  |
| Vital               | ysiclan: Th<br>is certificata<br>diractor, pag   | Be             | 25. Was case referred to medica examiner?   |                                      |                                   |                                   |               |                         |                          | 26. Place  | e of Death                 | (Check                 |                        |                          |                             |   |
|                     | d is   | 인              | 1 ☐ Yes 2 🛣 No  | Hospital:                            | 🗋 Inpatie                         | ent 2 ER/Ou                       | tpatient      | 3 🗆 DC                  | Othe Othe                | ar: 🔀 Nr   | ursing Hor                 | me 5 🗆                 | Residen                | ce 6 □Ot                 | ther (Specif                | ý)  |
| _                   | g lar  |                | 27. Manner of Death 1 X Natural 5 ☐ Pendi   | 28a. Da<br>(M                        | te of Inju<br>onth, Da            | ry 28b. 7                         | Time of njury | 2                       | 8c. Injury<br>Work       | at<br></td <td>2</td> <td>28d. Des</td> <td>cribe how</td> <td>injury occu</td> <td>irred</td> <td></td> | 2                          | 28d. Des               | cribe how              | injury occu              | irred                       |   |
| Sio                 | tendi<br>aath.<br>tor: A   | cati           |   | igation                              |                                   |                                   |               | М                       |                          | Yes 2□   |                            |                        |                        |                          |                             |   |
| Division of         | or Ati   | Certification: |   | nined 286. Pla                       | ice of Inj<br>ilding, et          | ury · At home, fa<br>c. (Specify) | rm, stree     | et, factory             | y, office                |  | 1                          | 28f. Loca<br>City      | tion (Stre<br>or Town, | et and Num<br>State)     | nber or Rura                | al Route Number,                            |
|                     | oltal ours a urs a |                | X   |                                      |                                   |                                   |               |                         |                          |  |                            |                        |                        |                          |                             |   |
|                     | To the Hospital or Attending Ph<br>within 24 hours after daath.<br>To the Funaral Director: Aftar th<br>complataly fillad in by tha funaral  | Medical        | 29a. Certifier 1 Certifyi (Check only 2 Medical one)  | ng Physician: To<br>Examiner: On the | the best<br>a basis o<br>anner st | f examination an                  | dor inve      | occurred<br>estigation  | at the tim<br>, in my of | ne, date ar<br>pinion, dea   | nd place, a<br>ath occurre | and due t<br>ed at the | time, date             | se(s) and m<br>and place | nanner as s<br>, and due to | tated.<br>o the cause(s)                    |
|                     | To the within 2 To the compla  | Mec            | 29b. Signature and title of certific  |                                      | anner St                          | 116U.                             |               | 290                     | c. License               | number   |                            |                        | 290                    | I. Date sign             | ed (Month                   | Day, Year)                                  |
| 1                   | F ₹ ₹ 8  |                | kuti  | Voh                                  | Le                                | M.,                               | り             |                         |                          | 0274   |                            |                        |                        | 6/24                     | 1/2006                      | )   |
| )                   | (6)  |                | 30. Name and address of person  | who completed a                      | ause of -                         | leath (Item 13=1                  | Cune D        | rint)                   |                          |  |                            |                        |                        |                          |                             |   |
|                     | روی  |                | Kirti Vohr  |                                      |                                   | Ley Blvd                          |               |                         | sda N                    | MD 2   | <b>0817</b>                |                        |                        |                          |                             |   |
|                     | Sta  | ate            | 31. Date filed (Month, Day, Year  | 32                                   | Registr                           | ar's Signature                    |               |                         | Juagi                    | 2  | 501/                       |                        |                        |                          |                             |   |
|                     | Regist   |                | JUL 0 3 20  | 06                                   | ik                                | # Ap                              | cons          |                         |                          |  |                            |                        |                        |                          |                             |   |
|                     |  |                |   |                                      |                                   |                                   |               |                         | _                        |  |                            |                        |                        |                          |                             |   |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amended #23a perMD FCHD, KS7/ Partificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** Steven Thompson 0/28PM 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Himose Rehabilitation Extended Care Baffimoya
If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1☑M 2□F Months Days 12-62-4950 Director FEB. 21, 195 FRETSERLYK Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits 28a-f ehov other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo HEDERUK JAMSVIILE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 4. SA. 9708 DRIVE iteme 23a Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deet Department of Health and Mental Hygiene. Important: If tem 27 is marked other the any injury or other traumant. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (4-12) College (1-4or 5+) LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ALFRED Thampson (JEORGE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SISTEA) 9708 oac DOOL DR. JAMSYILLEMA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State 1-11-06 4 ☐ Donation 5 ☐ Other (Specify), IJAMSY116 21. Signatur of Funeral Service 22. Name and Address of Facility GARY L. Rollins Functor Home 1. FRED AD. 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ailure End Stage Renal Diseaseun Known LUCY DAIL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Deficiency 2 **N**0 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 2 No 1 ☐ Yes 2 ☐ No 1 Yes After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar Boylevard, Beltimore, Maryland 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

32. Registre's Signature

31. Date filed (Month, Day Year)

|   | Amended item #5 per  | State of Marylan<br>f fh/wichd/7-1   |   |                              | 2. Date   | Reg. No. 2                                    | 6 22686<br>3. Time of Death   |
|---|--|--|---|------------------------------|---|---|---|
| Physician<br>/Medical   | Joseph James  4a Fecility Neme (If not institution, give   |  |   | 4b Cit                       | Mont<br>June                                      | 27 200  |   |
| Examiner  | Peninsula Regior   |  | Center  | Sa                           | lisbury   | Wicom   |   |
| Funeral<br>Director   | 5. Social Security Number 6. Sec. 13-16-7861 1220-28-4707  | 7. Age (In yrs. 87   | lest birthday) If Und<br>Month                        |                              | nder 24 Hrs. 8. Date<br>urs Min. 8. Date<br>(Mont | of Birth 9. h, Day, Yeer) 26 1918             | Birthplace (State or Foreign<br>Country)<br>Maryland                                |
| yland   | Usuel Residence of Decedent  10a. Stete 10b. County  | 10c. Cit   | y, Town or Location                                   |                              |   |   | 10d. Inside City Limits   |
| death with the Maryland ms 23e or 28e-f show rms to rotified at neral Director  | Maryland Wicomi  | ico  | Nantico   |                              |   | 40.00   | 1 □ Yes 2 No  |
| th with the 23s or 2  | 10e. Street end Number   | 3  | 101. 2  | ip Code<br>21840             |   | 10g. Citizen of Wha                           | it Country?   |
| or the  | 20841 Nutter Ro  | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 2 ☑No<br>If Yes, Give<br>Year or Dates: |   |                              | c Origin? (Specify Yes<br>xican, Puerto Rican, et | or No-<br>Black, \<br>Specify:                | American Indian,<br>White, etc.   |
| i i   | 15. Decedent's Edu<br>(Specify only highest gred   | cation   | 16a. Decedent's Us<br>(Give kind of v<br>life. DO NOT | ork done during              | most of working                                   | 16b. Kind of Busin                            | Black<br>ess/Industry   |
| her tha   | 7<br>17. Father's Neme (First, Middle, Last)   |  | Water   |                              | Anthor's Name (First A                            | None  |   |
| and Mental Hygie<br>is marked other i<br>aumatic event, the<br>To Be Co   | James Albert Tu  | ırner Sr.  |   |                              | da Jones  | idule, Maidell Sulliante)                     |   |
| and M<br>is mar<br>aumat  | 19a. Informant's Name/Relationship (T)   |  | _   |                              |   | Number, City or Town, Sta                     | ite, Zip Code)  |
| t of Health   | Jackson Turner S  20a. Method of Disposition  1  Burial 2 Cremation 3 CF   | 20b. Felloward from State  | Place of Disposition (Notemberry, crematory of        | ame of<br>other place)       | Date  | 20c. Location - Cit                           |   |
| rtant   | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens  |  | race Ceme   |                              |   | 06 Tyaskin                                    | ,Md.  |
| Depa<br>impo<br>any i   | Hladys B.  | Stewart  |   |                              | eral Home<br>L.Salisbu                            | e<br>ry,Md.2180                               | 1   |
| hysician<br>/Medical<br>examiner  | Immediate Cause (Final disease or condition resulting in death)  | b  | or as a consequence of                                | 2                            | Disu  | 73-   | Onset and Death   |
| ding physician and ise as the burial-transit  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | 0,   | r as e consequence of                                 | Mes                          |   |   |   |
| e attendin<br>ed for use<br>sician/N  | Part II. Other significant conditions con  | ntributing to death but not res  | ulting in the underlying                              | cause given in F             | Part I. 23b.                                      | . Did tobacco use contril                     | bute to the cause of death  |
| been signed by the attending should be deteched for use exieted by Physician/Me   |  |  |   |                              |   | 1 ☐ Yes 2 ☐ No 3[                             | ☐ Probably 4 ☐ Unknow   |
| S 60 C  |  |  |   |                              | 24a.  | Wes an autopsy performed?                     | 4b. Were autopsy findings<br>available prior to<br>completion of cause<br>of death? |
| certificate has t<br>irector, page 2 s  |  |  |   |                              |   | 1⊡ Yes 2⊾Nu                                   | 1 ☐ Yes 2 ☐ No  |
| his certifical director   | 25. Was case referred to medical examiner?   | lospital: 1 ☐ Inpatient 2 ☑  | ER/Outpatient 3 [                                     | Other:                       | Place of Death (Check                             | only one) Residence 6 □Other (                | Specify)  |
| within 24 hours effer death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page  Medical Certification: To Be Com | 27. Manner of Deeth  1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Injury<br>(Month, Dey Year)   | 28b. Ti <i>m</i> e of<br>Injury<br>M                  | 28c. Injury at Work? 1 ☐ Yes | 28d. Desc   | cribe how injury occurred                     |   |
| n 24 hours effer death.  • Funeral Director; Atter to letely filled in by the funeral edical Certification:   | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined  | 28e. Plece of Injury · At h<br>building, etc. (Specif  | ome, farm, street, facto<br>y)                        | ry, office                   |   | tion (Street and Number of<br>or Town, Stete) | or Rural Route Number,  |
| 24 hour<br>Funer<br>stely fill<br>dical   |  | sician: To the best of my kno<br>ner: On the basis of examina<br>end manner stated.            |   |                              |   |   |   |
| within<br>To the<br>comple  | 29b. Signature and title of certifier  |  |   | 9c. License nu <i>m</i>      |   | 29d. Date signed (A                           |   |
| mp  | 30. Neme end address of person who or  | ompleted cause of death (Iter  | π 23e) (Type, Print)                                  | Hoo                          | 56157   | 7/3/30  | 6   |
| <i>[1]</i>  | Rose   | + A Wa   | 218   | New!                         | w ST Sx   | 1:sky MS                                      | 2180)   |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)  | 32. Régistrar's Signa  | de Coarle   | 9                            |   | ·   | /   |

|                                 |  | •              | For<br>State<br>Registrar   | State of M  | larylan                       |                                 |  |                     | ealth a<br>Death                       | and M                    |   | iene       | 200                                 | 6                       | 22                       | 687         |
|---------------------------------|--|----------------|---|---|-------------------------------|---------------------------------|--|---------------------|--|--------------------------|---|------------|-------------------------------------|-------------------------|--------------------------|-------------|
|                                 | Dhoratai   |                | 1. Decedent's Name (First, Middle, Last   | )   |                               |                                 |  |                     |  |                          | 2. Date of Deat<br>Month                    |            | Yea                                 |                         | 3. Time o                | of Death    |
|                                 | Physici:<br>/Medic   |                | Thedora Lee   |   |                               |                                 | ,  |                     |  |                          | June  | 27         | 200                                 |                         | 23:                      | 15 M        |
|                                 | Examin   | er             | 4a. Facility Name (If not institution, give PONINSULA REGIONAL                          | street and number   | at 1                          | WER                             | 4b. City                                   | , Town, or<br>مرک   | Location of                            | of Death                 |   | 4c. C      | ounty of De                         |                         | co                       |             |
|                                 | Funeral<br>Director  |                | 218-34-3204   | x 7. A  | ge (In yrs.<br>68             | last birthday)<br>Yrs.          | If Unde<br>Months                          | Days                | If Under a                             | Min.                     | 8. Date of Birth<br>(Month, Day,<br>July 19 | , 193      | 9. 8                                | irthpla<br>Counti<br>MD | (y)                      | or Foreign  |
|                                 | land<br>bw   |                | Usual Residence of Decedent  10a. State 10b. County                                     |   | 10c. Cit                      | y, Town or Lo                   | cation                                     |                     |  |                          |   |            |                                     | 10                      | d. Inside C              | City Limits |
|                                 | Mary   | ō              | MD Wicomic  | n   | P                             | arsons                          | hura                                       |                     |  |                          |   |            |                                     |                         | 1 🗌 Ye                   | s 2X No     |
|                                 | r 28a  | Director       | 10e. Street and Number  |   | -                             | u1 301131                       |  | p Code              |  |                          | 10  | 0g. Citize | n of What                           | Count                   | ry?                      |             |
|                                 | th with  |                | 33448 Shavox Rd.  |   |                               |                                 | 2  | 1849                |  |                          |   | USA        |                                     |                         |                          |             |
| 36                              | 2 should be filed within 72 hours after death with the Maryland and Menth Hygiene. Is marked other then "natural; or lieme 23e or 28e-f ehow aumatic event, the Madical Exacultier must be notified at   | by Funeral     | 11. Marital Status  1 ☐ Never Married 2 ☒ Marned  3 ☐ Widowed 4 ☐ Divorced              | 12. Was Deceden<br>Armed Forces<br>1 Tyes 2 If Yes, Give<br>Year or Dates | i?<br><b>K</b> No             | 1                               | Was Dece<br>If Yes, spe<br>1 \( \text{Yes} | ecify Cuba          | ispanic Orig<br>n, Mexican<br>Specify: | gin? (Spe<br>i, Puerto f | cify Yes or No-<br>Rican, etc.)             |            | Race - Ar<br>Black, Wi<br>pecify: W | nite, e                 | tc.                      |             |
| ŏ                               | 2 hou  | ted            | 15. Decedent's Edu  |   |                               | 16a. Dece                       | dent's Us                                  | al Occupa           | ation                                  |                          |   | 16b. Kind  | of Busines                          | ss/Indi                 | ustry                    |             |
| 21/2                            | thin 7   | Completed      | (Specify only highest grade<br>Elementary/Secondary (0-12)                              | College (1-4o   | 5+)                           | life.                           | DO NOT                                     | use retired         | during most<br>)                       | t of workin              | ng  |            |                                     |                         |                          |             |
| 7                               | ed wi  | Cou            | 12  |   |                               | Homer                           | naker                                      | •                   |  |                          |   |            | n Home                              | 5                       |                          |             |
| Baltimore, Maryland 21215-0036  | 0  | Be             | 17. Father's Name (First, Middle, Last)   |   |                               |                                 |  |                     |  |                          | (First, Middle, M                           | Maiden S   | umame)                              |                         |                          |             |
| Ĕ                               | permit. Pages 1 end 2 should by<br>Department of Heelth and Menta<br>Important: If item 27 is marked<br>any fijury or other traumatic ed<br>2006.  | ဥ              | Sewell Clark  19a. Informant's Name/Relationship (T)                                    | (ne Print)  |                               | 10b Mailie                      | a Addros                                   | s (Stroot s         |  |                          | Timmons<br>Route Number,                    | Cityon     | Town Ctota                          | 7:- /                   | Code)                    |             |
| <u>S</u>                        | th an  |                | Wilson Morris Tow   |   |                               |                                 |  |                     |  |                          | onsburg.                                    |            |                                     |                         | ,0de)                    |             |
| re,                             | r Hee  | 1              | 20a. Method of Disposition  |   | 20b. F                        | Place of Dispo                  |  |                     |  |                          | -   |            | ation - City                        |                         | n, State                 |             |
| ê<br>E                          | Pages<br>ent of<br>nt: If I  |                | 1 🖾 Burial 2 □ Cremation 3 □ F<br>4 □ Donation 5 □ Other (Specify)                      |   | ື Fo                          | rest Gi                         | <sup>natory</sup> or<br>℃OVE               | Ceme                | tery                                   | 7-1-0                    | 06 F  | arso       | onsbur                              | ^a.                     | Md.                      |             |
| <u>=</u>                        | mit. I<br>partm<br>ports<br>/ inju   | 1              | 21. Signature of Funeral Service Licens   |   |                               |                                 |  |                     |  |                          | Burbage                                     |            |                                     |                         |                          |             |
| Õ                               | Departing Important from the suny from the sun fro | , Į            | Yacaroline.   | 4 Das   | soute                         |                                 | 108  | Will                | iam S                                  | t., [                    | Berlin,N                                    | 1d. 2      | 21811                               |                         |                          |             |
|                                 |  |                | 23a. Part1. Enter the disease, or comp<br>shock, or hear failure. List only o           | lications that cause<br>ne cause on each                                  | the deal                      | Do not ent                      | er the mo                                  | de of dyini         | g, such as                             | cardiac o                | r respiratory arre                          | est,       |                                     |                         | Approxima<br>Interval Be | etween      |
| 8                               | Physician  |                | Immediate Cause (Final disease or condition   | a. Anux   | c Re                          | enal                            | Fail                                       | ne                  |  |                          |   |            |                                     |                         | Onset and                | I Death     |
|                                 | /Medical<br>Examiner   |                | resulting in death)   | Due to (or a  | s a conseq                    | uence of):                      |  |                     |  |                          |   |            |                                     | 1                       | 1                        |             |
|                                 | Zaamme.  | _              | Sequentially list conditions,   | b. Sepsis   | 744                           | drome                           |  |                     |  |                          |   |            |                                     | a                       | 1945                     |             |
|                                 | nsit   | nine           | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury           | ASC   | -                             | dance ory.                      |  |                     |  |                          |   |            |                                     |                         |                          |             |
|                                 | execunand nand all-tra   | Examiner       | that initiated events<br>resulting in death) Last                                       | c. Due to (or a   |                               | uence of):                      |  |                     |  |                          |   |            |                                     | -                       |                          |             |
| 8760,                           | cate be executed<br>physician and<br>the burial-transit  | dicail         |   | d.  |                               |                                 |  |                     |  |                          |   |            |                                     |                         |                          |             |
| 9                               | tificat<br>g phy<br>as th  | ledi           |   |   |                               |                                 |  |                     |  |                          |   |            |                                     |                         |                          |             |
| O. Box                          | The law requires that the death certific<br>sie hes been signed by the attending p<br>page 2 should be detached for use as   | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcom<br>1 □ Live birth<br>4 □ Pregnant<br>9 □ Unknown      | 2 Feta                        | death 3□                        | ⊒Ectopic p<br>⊒ Other (s                   | pecify)             |  |                          |   | 23         | d. Date of d<br>Month               |                         |                          | Year        |
| Division of Vital Records, P.O. | signed by  | à              | Part II. Other significant conditions co  |   | but not res                   | ulting in the u                 | nderlying                                  | cause give          | en in Part I.                          |                          | 23e. Did tob                                | acco use   |                                     |                         | cause of                 |             |
| S                               | w requir<br>been s<br>should   | ete            | Morbid Obert  |   |                               |                                 |  |                     |  |                          | 24a. Was a                                  | .          | 24b. Were                           | auton                   | au finding               | o nyaylabla |
| al Re                           | sician: The lav<br>certificete hes<br>irector, page 2  | Completed      |   |   |                               |                                 |  |                     |  |                          | autops:<br>perform                          | y          | prior to death'                     | o com                   | pletion of o             | cause of    |
| څ                               | Physician:<br>r this certifice<br>ral director, p  | ) Be           | 25. Was case referred to medical examiner?  1 Yes 2 No                                  | Hospital: 1 (1) Inpa  | · 0 🗆                         | 50/0                            |  | OA Othe             |  |                          | Check only on                               |            |                                     |                         |                          |             |
| of                              | Phy<br>er this   | n: To          | 27. Manner of Death   | 28a. Date of In   | iurv                          | ER/Outpatier<br>28b. Time of    |  | 28c. Injury<br>Work | 4 🗆 140                                |                          | ne 5 Reside                                 |            |                                     | oecity)                 |                          |             |
| ion                             | Attending it death.  | atio           | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation                                       | (Month, E   | ray Year)                     | Injury                          | м  |                     | <br Yes 2 ☐ I                          | No                       |   |            |                                     |                         |                          |             |
| Divis                           | P  | Certification: | 3 Suicide 6 Could not be determined   | 28e. Place of I<br>building,  | njury - At ho<br>etc. (Specif | ome, farm, str                  | reet, facto                                | ry, office          |  | 2                        | 18f. Location (St.<br>City or Town          |            | Number or                           | Rural                   | Route Nur                | mber,       |
|                                 | he Hospitat<br>n 24 hours a<br>he Funeral Dietely filled   | edicai         | 29a. Certifier 1 € Certifying Phy (Check only one) 2 ☐ Medical Exam                     | rsician: To the besiner: On the basis and manner:                         | of examina                    | wledge, deat<br>ition and/or in | h occurred<br>vestigatio                   | at the tim          | ne, date and<br>pinion, deat           | d place, a<br>th occurre | and due to the ca                           | use(s) a   | nd manner<br>lace, and d            | as sta<br>ue to t       | ted.<br>the cause(       | (s)         |
|                                 | To the within 2 To the complet   | ž              | 29b. Signature and title of certifier   |   |                               |                                 | 29   | c. License          | number                                 |                          | 25  | d. Date    | signed (Mo                          | nth, D                  | ay, Year)                |             |
|                                 |  |                | 4 X////-  | DO.   |                               | <u> </u>                        |  | Hoc                 | 2490                                   | 34                       |   | 61         | 28/0                                | 16                      |                          |             |
| 1                               | 0  |                | 30. Name and address of person who c  | ompleted cause of   | death (Item                   | n 23a) (Type,                   | Print)                                     | ·+ <                | -/                                     | /                        | y, Md                                       | ,          | 216-                                |                         |                          |             |
|                                 | Sta  | te             | 31. Date filed (Month, Day, Year)   | 32 Aegis  | trar's Signa                  | ature                           | 0  | /                   | 17115                                  | DUN                      | 4, 1010                                     | . 0        | 100                                 | /                       |                          |             |
|                                 | Registi  |                | JUL 0 3 20  | US DE   | 2                             | J 40                            |  | •                   |  |                          |   |            |                                     |                         |                          |             |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** CANDIDA CARMELA MUNOZ URIZAR 29, June 1:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2 💢 F 225-51-4093 70 Yrs. Director July 16,1935 Guatemala Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla ment of Heetith and Mental Hygiene.

ant: If Item 27 Is marked other then "natural", or Iteme 23a or 28a-1 ehov yry or other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2X No Director Gaithersburg Montgomery Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9100 Centerway Road 20879 Guatemala Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2□ No Specify:Guatemalan Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Housekeeping 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vidalia Urizar Nemecio Munoz Gamez ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Concha Anaharia Munoz (Daughter) 9100 Centerway Road Gaithersburg, Md. 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Chicaman, Quiche, permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 11, Cementerio Chicaman 4 ☐ Donation 5 ☐ Other (Specify) Guatemala 21. Signature of Funeral Servia Lice 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877 Elter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Part 1 Immediate cause (Final disease or condition resulting in death) Pnysician Cardiac Arrest /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 2 🗆 No 1 Yes 2₽ No 1 Tyes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours after To the Funerel Dire 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60548 6/29/2006 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Dr. Thomas Odar M.D.

JUL 03 2006

31. Date filed (Month, Day, Year)

15225 Shady Grove Rd. #201

32 Registrar's Signature

Rockville, Md. 20850

#### Please Type or Print in Black Indelible Ink

| Brian Michael Willi  | 1<br><u>F</u>  | - For State  |   | rtment of<br>fificate of              |  | d Mental H                      | Re                                     | eg No                                | 16 2268  |
|--|----------------|--|---|---------------------------------------|--|---------------------------------|--|--------------------------------------|--|
| Physician<br>Medical Examine   | 3.0            | 1. Decedent's Name (First, Middle,Last)  Brian Michael Willi   | ams   |                                       |  |                                 | 2. Date of Deat<br>Month<br>June 30, 2 | Day Year                             | 3. Time of Death 0845 hrs                          |
|  |                | <ol> <li>Facility Name (if not institution, give street and n</li> <li>2011 Starlight Drive Apt. A</li> </ol>  | umber)  |                                       | b. City, Town, or<br>Hagerstown                            | Location of Death               | 1                                      | 4c. County of De. Washington         | ath  |
| Funeral<br>Director  |                | 5. Social Security Number 6. Sex 1 X M 2 F   | 7. Age (In yrs. la:<br>24                         | st birthday)<br>Yrs.                  | If Under 1 Year<br>Months Day                              | <del></del>                     | _                                      | h(MM/DD/YYYY) 9. f                   | Birthplace (State or<br>eign<br>Country) AR        |
| or Maryland or 28a-f show any fied at once.  |                | Usual Residence of Decedent  10a State 10b County  MD Washington  10e Street and Number  |   | Town or Location                      |  |                                 | 110                                    | g. Citizen of What Co                | 10d Inside City Limits 1 Yes 2 X No                |
| h the Maryland<br>3a or 28a-f sh<br>otified at once  |                | 2011 Starlight Lane, Ap  | t. A  |                                       | 21740  |                                 |  | US                                   | y .  |
| Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: for item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Re Commission by Eumaral Director  | 2              | 11. Marital Status 1 X Never Married 2 Married 1 1 Yes, 3 Widowed 4 Divorced If Yes, Give Yro Dates:  15. Decedent's Education (Specify only highest gra | 2 X No  | If Ye                                 | es, specify Cubar  Yes $2 \mathbf{X}$ No  t's Usual Occupa | tion (Give kind of              | Rican, etc.)                           | White, etc.                          | erican Indian, Black,  Black s/Industry            |
| 36<br>iin 72 ho<br>thau "ma<br>dical Ex.   | Сотрыетеа      | Elementary/Secondary (0-12) College 12   | 1-4 or 5+)  | during mo                             | ost of working life<br>Stocke:                             | DO NOT use ret                  | red)                                   | Reta                                 | i 1  |
| 215-00; be filed with intal Hygiene riked other tent, the Me   | ů<br>n         | 17. Father's Name (First, Middle, Last)<br>Quinten Monroe Williams   | i   |                                       |  | 18.Mother's Name<br>Ruby L      | ois Sett                               | laiden Surname)<br>les               |  |
| AD 21<br>2 should<br>h and Me<br>27 is ma<br>imatic ev   | - 1            | 19a Informant's Name/Relationship (Type, Print) Quinten M. Williams / F  | ather   | 19b. Mailing 401 H                    | Address (Stree   | Avenue,                         | Rural Route Num<br>#301, H             | ber, City or Town, Sta<br>lagerstown | te, Zip Code)<br>, MD 21740                        |
| Baltimore, MD 21215-0036 vernit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If tiem 27 is marked other than njury or other traumatic event, the Medica   |                | 20a Method of Disposition  1 X Burial 2 Cremation 3 Removal 4 Donation 5 Other Specify   | rom State cr                                      | ematory or oth                        |  |                                 | Date 11/2006                           | 20c. Location - City                 |  |
| Balt permit Depart Import  |                | 21. Signature of Euneral Service Licensee  | 2   | 22. N                                 | ame and Address  | s of Facility Ge:<br>tomac St   | rald N.                                | Minnich Fugerstown,                  | nis, AR<br>uneral Home<br>MD 21740                 |
| Physician<br>/Medical<br>Examiner  |                |  | caused the death. Inotgun Wound a consequence of) | Do not enter th                       |  |                                 |  |                                      | Approximate Interval<br>Between Onset and<br>Death |
| led Insit  |                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Crisease or minury that mithated                               | a consequence of)                                 | :                                     |  |                                 |  |                                      |  |
| cuted cuted ind transit  |                | events resulting in death) Last Due to (or as  | a consequence of)                                 | :<br>                                 |  |                                 |  |                                      |  |
| Division of Vital Records, P.O. Box 68760, within 24 hours after death executed within 24 hours after death for the Purposition of the formal Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of certification. To Be Completed by Division and Experient Control Contribution in the control of the control o | cian/injedice  | 3b. Was decedent pregnant in the past 12 months?   | outcome of pregna<br>birth<br>nant at time of dea | 2 Fet                                 | al death 3   | Ectopic pregna                  | ancy                                   | 23d. Date of delive<br>Month         | ery<br>Day Year                                    |
| ). Box: the death by the attend for the Dhyesis  | uysic          | 1 Yes 2 No 9 Unknown 9 Unknown   |   | - 0.11                                | ner (Specify)  | since in Road                   | 220 Did tol                            |                                      | the serve of death?                                |
| ds, P.O. Ba<br>equires that the de<br>een signed by the<br>ould be detached f  | 2              | Part II. Other significant conditions contributing   | o death but not res                               | suiting in the ai                     | nderlying cause (  | given in Part I.                |  | pacco use contribute to 2 ✓ No 3 Pr  |  |
| Division of Vital Records, P.O. ours after death and Physician: The law requires that the ours after death. After this certificate has been signed by filled in by the funeral director, page 2 should be detach contification. To Be Completed by Description of the property of the property of the property of the page 2 should be detached by Description.  | Completed      |  |   |                                       | 00.51  |                                 | autops<br>perform<br>1 <b>V</b> Yes 2  | sy prior to<br>med? death?           | completion of cause of                             |
| F Vital Physician r this cert al directo   | Ď              | 25. Was case referred to medical examiner?  1  Yes 2 No  | Inpatient 2 E                                     | R/Outpatient                          |  | of Death (Check<br>Other Nursir |  | Residence 6 🗸 Oth                    | er: Scene  |
| Sion of Vividending Physicath<br>death<br>vetor: After this<br>by the funeral dir  | Certification: | 1 Natural 5 Pending FOUN Jun 30  | h, Day Year)<br>D:<br>2006                        | 28b. Time of Ir<br>FOUND:<br>0840 hrs | 1 1  | ry at Work?<br>Yes 2 ✔ No       | Subject shot                           |                                      |  |
| Division  To the Hospital or Attent within 24 hours after death To the Fineral Director: completely filled in by the   |                | Suicide Could not be   | Multi-Family                                      | Apt.                                  |  |                                 | or Town, St<br>2011 Starligh           | <sup>ate)</sup><br>nt Drive, Hagerst |  |
| To the Hos within 24 h Completely  |                | one) 2 Medical Examiner: On the basis and manner   | of examination and                                |                                       | on, in my opinior  | , death occurred a              |  | and place, and due to                | the cause(s)                                       |
|  |                | 29b Signature and title of certifier  AUCH HAU   | lan   |                                       | 29c. Licens  |                                 |  | July 1, 2006                         | lonth, Day.Year)                                   |
| 54-2   |                | 30. Name and address of person who completed car<br>Carol Allan, MD Assistant Medica   |   |                                       | Street, Baltim   | ore, MD 2120                    | 1                                      |                                      |  |
| Stat<br>Registra   | ie<br>ar       | 31. Date filed ( <i>Month, Day</i> , Year) 6 2006 32. F  | eistrar's Signatur                                | 4. Spe                                | the .  |                                 |  |                                      |  |
| DHMH TI Roll 1, 00   | _              |  | 3/3   | ORIGINAL                              | 2.0  |                                 |  |                                      |  |

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 30, 2ีปั06 Ruth Virginia Wastler **Physician** 9:12 P. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Thurmont 311 E. Main Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2€ F 1921 September 24, Yrs Maryland 217-18-8865 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f ahow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygeiner.

The control of Health and Mental Hygeiner and the state of Health and Mental Hygeiner. The marked other than "natural", or items 28s or 28s-1 ahov ury or other traumatic avent, the Medical Examinating the restitined at ury or other traumatic avent, the Medical Examination. Frederick Thurmont 1X Yes 2 No Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21788 311 E. Main Street Be Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) garment factory worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Catherine Shook Ernest Raymond Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1415 Foxwood Court, Annapolis, Maryland Mark Wastler - grandson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-5-2006 Thurmont, Maryland permit. Page Department of Important: If any injury or ance. Blue Ridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Servic Censee 22. Name and Address of Facility Stauffer Funeral Home (Me 104 E. Main Street, Thurmont, Maryland 21788 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death of Unknown Immediate Cause (Final Metustatic Carcinoma uegy **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes 21X No After this certification Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 5 Pending investigation 1 Tes 2 No within 24 hours after death. To the Funeral Director: Af 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Function (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 46B Thomas Johnson Drive ; Frederick mo 21702 Kanan Hudhwa 32. Registr 31. Date filed (Month, Day, Year) State Registrar

06-04565 Michael White

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

|  |                | or State  | Certificate of Death              |                        |                                |              |                         |                         |                        |                          |                         |                           | eg No           | 4                |                           | <u> </u>  | 7        |
|--|----------------|---|-----------------------------------|------------------------|--------------------------------|--------------|-------------------------|-------------------------|------------------------|--------------------------|-------------------------|---------------------------|-----------------|------------------|---------------------------|---|----------|
| Physician/   | 1.             | Decedent's Name (First, Middl   | Middle,Last) MICHAEL THOMAS WHITE |                        |                                |              |                         |                         |                        |                          | Date of Dea<br>Month    | Day                       | Year            | 3                | Time of Death<br>1015 hrs |   |          |
| ledical Examine  |                |   |                                   |                        |                                | S WHI        |                         | City To                 | aun orle               | ocation of               |                         | lune 29,                  |                 | ounty of         | Death                     |   | $\dashv$ |
|  | 4a             | . Facility Name (if not institution 12964 Woodsboro Pile  |                                   | et and num             | iber)                          |              | 4                       | Keyma                   |                        | ocation of               | Dealli                  |                           |                 | derick           | Jodu.                     |   |          |
|  | -              | Social Security Number  | 6, Sex                            | 7                      | . Age (In y                    | rs. last bir | thday)                  | If Under                |                        | If Under                 | 24Hrs. 8                | B. Date of B              | rth (MM/DE      |                  |                           | place (State or                                   | ┪        |
| Funeral<br>Director  |                | 215-33-2151   | 1 X M                             |                        |                                | 14           |                         | Months                  | Days                   | Hours                    | Min.                    | Ju1y                      | 19, 1           | 991              | Foreign<br>Coun           | ntry)Mary1and                                     |          |
| ž.   |                | sual Residence of Decedent  a State 10b County  |                                   |                        | 10c.                           | City, Towr   | or Location             | on                      |                        |                          |                         |                           |                 |                  | 1                         | 10d Inside City Limits                            | 1        |
| ow any   | М              | laryland Fred   | erick                             |                        | K                              | eymaı        | c                       |                         |                        |                          |                         |                           |                 |                  |                           | 1 Yes 2 X No                                      | ,        |
| Maryland 28a-f show d at once.   | 10             | e Street and Number   |                                   |                        | 1                              |              |                         | 10f Zip                 | Code                   |                          |                         | T                         | 10g Citizei     |                  |                           | y?  | ٦        |
| D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f she rate event, the Medical Examiner must be notified at once Tro Do Commissioned by Emperal Director  |                | 1330 Baker Roa  | ad                                |                        |                                |              |                         | 21                      | 757                    |                          |                         |                           | U               | .S.A             | . •                       |   | ╛        |
| with ms 23 be no   | 1              | Marital Status  |                                   | Was Dece<br>Armed For  | dent Ever                      | ın U.S.      | 13. Was                 | Deceder<br>es, specify  | nt of Hisp<br>Cuban, I | anıc Orıgı<br>Mexican, I | n? ( Spec<br>Puerto Ric | fy Yes or N<br>can, etc.) | 0- 14           | Race -<br>White, |                           | an Indian, Black,                                 |          |
| r death with or items 23 must be no  | 1              |   | 1                                 | Yes                    | 2 X                            | 10           | 1                       | Yes 2                   | V No                   | snecify:                 |                         |                           | Sı              | pe <i>cify</i> : | Wh                        | ite   |          |
| hours after<br>'natural",<br>Examiner  | ے ا            | Widowed 4 Div<br>15. Decedent's Education (Spe  | vorced If Yes                     | ites:                  | e complete                     | d) 16a       | Decedent                | 's Usual (              | Occupatio              | n (Give ki               | ind of wor              | k done                    |                 | d of Busi        |                           |   | $\dashv$ |
| 5-0036 led within 72 hours after bygiene other than "natural" the Medical Examine  | <u> </u>       | Elementary/Secondary (0-12)   |                                   | College (1-            |                                | _            | during mo               | st of work              | king life. I           | DO NOT L                 | ise retired             | )                         |                 |                  |                           |   | 1        |
| thin 7   |                | 9   | ĺ                                 |                        |                                |              | S                       | tude                    |                        |                          |                         |                           |                 | N/A              |                           |   | 4        |
| 5-0036 Jed within 7 Hygiene I other than   | 3 1            | 7. Father's Name (First, Middle   | , Last)                           |                        |                                |              |                         |                         |                        |                          | ,                       | irst, Middle,             | Maiden Si       | urname)          |                           |   |          |
| 2121<br>ould be fit.<br>Mental 1<br>marked<br>ic event.  | ם              | Thomas Lee Wh. 9a Informant's Name/Relation   |                                   | Drint \                |                                | T 19         | ah Mailing              | Address                 | (Street                | Chery                    | JI Ot<br>beror Run      | : <b>t</b><br>al Route Nu | ımber. Citv     | or Town.         | State.                    | Zip Code)   | 113      |
| Baltimore, MD 21215-003 permit Pages I and 2 should be filled within Department of Health and Mental Hygiene Important: If item 27 is marked other Uniqury or other traumatic event, the Med   | 2 1            | Thomas L. Whi   |                                   |                        | r                              |              |                         |                         |                        |                          |                         | ar, M                     |                 |                  |                           |   |          |
| s, M<br>and 2<br>lealth<br>tem 2<br>traun  |                | 0a. Method of Disposition   |                                   |                        | 12                             | 20b. Place   | of Dispos               | ition (Nan              | ne of cem              |                          |                         | Date                      |                 |                  |                           | own, State  |          |
| Nore ages 1 at of H  | -4             | Burial 2 Crematic   |                                   | emoval fro             |                                |              | a Cen                   |                         |                        |                          | 7/3/0                   | )6                        | Utic            | a, M             | lary                      | land  |          |
| Baltimore, MD permit Pages Land 2 sht Department of Health and Department of Health and Department If item 27 is injury or other traumati  | 2              | Donation 5 Other S  1 Signature of Funeral Service  | Specify:<br>License               |                        |                                | 0010         |                         |                         | -                      |                          |                         | ON FU                     |                 |                  |                           |   |          |
| Balti<br>permit<br>Departn<br>Importi  | 1              | Relitz  | X                                 | Luce                   | 7                              |              | 615                     | EAS                     | T MA                   | TN S                     | CREET                   | THU                       | RMONT           | . MD             | 21                        | 788   |          |
| Physician  | 2              | 3a. Part I Enter the disease, of failure. List only one caus  | r con olicati<br>e on each lir    |                        | aused the o                    | death. Do    | not enter ti            | ne mode o               | of dying, s            | such as ca               | ardiac or r             | espiratory a              | rrest, shoc     | k, or hear       | t                         | Approximate Interva<br>Between Onset and<br>Death |          |
| /Medical<br>Examiner   |                | mmediate Cause (Final diseas<br>or condition resulting in death)                                    | _                                 | wning                  |                                |              |                         |                         |                        |                          |                         |                           |                 | _                |                           | Dealii  | -        |
|  |                |   | b                                 | to (or as a            | conseque                       | nce or).     |                         |                         |                        |                          |                         |                           |                 |                  |                           |   |          |
|  | اَ إِحَ        | Sequentially list conditions, f any, leading to immediate   |                                   | to (or as a            | conseque                       | nce of):     |                         |                         |                        |                          |                         |                           |                 |                  |                           |   |          |
|  | Ε              | cause. Enter Underlying Caus<br>Disease or injury that initiated<br>events resulting in death) Last | Duo.                              | to (or as a            | conseque                       | nce of)      | -111                    |                         |                        |                          |                         |                           |                 |                  | _                         |   | ᅥ        |
| 760,<br>icate be executed<br>physician and<br>the burial - transit   |                | events resulting in death) Last   | d                                 |                        |                                |              |                         |                         |                        |                          |                         |                           |                 |                  |                           |   | _        |
| Records, P.O. Box 68760, The law requires that the death certificate be executed ricate has been signed by the attending physician and page 2 should be detached for use as the burial - transi  | n/Medical      | UNPENDED  | _ AN                              | MENDED                 |                                |              |                         |                         |                        |                          |                         |                           |                 | -                |                           |   |          |
| frate be physicilar the burit  | Ĭ,             | F FEMALE. 3b. Was decedent pregnant in  | Aller and                         |                        | outcome of                     | pregnanc     |                         |                         | 3                      | Ectopic                  | pregnan                 | 21/                       |                 | Date of o        | -                         | ay Year   |          |
|  | ian            | past 12 months?   | 1 4                               | Live b                 | oirth<br>nant at time          | of death     |                         | etal death<br>ther (Spe |                        | Lotopic                  | pregnam                 | -y                        |                 | FIGURE           |                           | <b>.</b> ,  |          |
| Box 68 e death certif  | >              |   | nknown g                          | Unkno                  | own                            |              |                         |                         |                        |                          |                         |                           | 1               |                  |                           |   |          |
| of Vital Records, P.O. Box 68 ling Physician: The law requires that the death certified After this certificate has been signed by the attending functal director, page 2 should be detached for use as   |                | Part II. Other significant cond   | ditions cor                       | tributing to           | o death but                    | not result   | ing in the              | underlying              | g cause g              | iven in Pa               | art I.                  |                           |                 |                  |                           | the cause of death?<br>ably 4 Unknown             | 1        |
| ires that signed!  | b p            |   |                                   |                        |                                |              | _                       |                         |                        |                          |                         | 124a Wa                   |                 | _                |                           | topsy findings availab                            | _        |
| ords   | Completed      |   |                                   |                        |                                |              |                         |                         |                        |                          |                         | aut                       | opsy<br>formed? | p                | nor to o<br>eath?         | ompletion of cause of                             |          |
| Cecc   | E O            |   |                                   |                        |                                |              |                         |                         |                        |                          |                         | 1 Ye                      |                 |                  | <b>√</b> Ye               | s 2 No  |          |
| al R   | Be C           | 25 Was case referred to medi<br>examiner?   |                                   | utal:                  |                                |              |                         |                         |                        | of Death<br>Other        |                         | -                         | 7.0             | 0.5              | 4 Other                   | Coope   | _        |
| of Vital Recoling Physician: The law<br>After this certificate has<br>uneral director, page 2 si   | ا ي            | 1 ✓ Yes 2 No  | Host                              |                        | Inpatient                      |              | Outpatien  b. Time of   |                         | JUA                    | ry at Work               |                         | Home 5                    | Resider         |                  |                           | Scene   | _        |
| Sion of Vital  <br>Attending Physician:<br>r death.<br>retor: After this certif<br>by the funeral director.  |                | 27. Manner of Death  1 Natural 5 Pe   | ending                            | FOUNE                  | of Injury<br>h, Day,Year)<br>: | F            | OUND:                   | injury i                |                        | Yes 2                    | . In                    | eceased                   |                 |                  |                           |   |          |
| Sion<br>Attend<br>death<br>ector:  | cati           | 2 🗸 Accident In   | vestigation                       | Jun 29,<br>28e, Plac   | 2006<br>ce of Injury           |              | )15 hrs<br>, farm, stre | et, factor              | y, office b            | ouilding, e              | tc. 2                   |                           |                 | nd <b>N</b> umbe | er or Ru                  | ral Route Number, Cit                             | ty       |
| Division of Vital Records, P.O. teal or Attending Physician: The law requires that the ras after death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.  | Certification: | de  | ould not be<br>etermined          |                        | Creek                          |              |                         |                         |                        |                          | 1                       | or Town<br>2964 W         |                 | Pike,            | Keym                      | ar, MD  |          |
| Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the  |                | 29a. Certifier 1 Cortifuing   | Physician:                        | To the be              | st of my kn                    | owledge,     | death occu              | urred at th             | e time, da             | ate and pl               | ace, and o              | due to the ca             | ause(s) and     | d manner         | as star                   | red   |          |
| o the lithin 2 or the long the | Medical        | (Check only one) 2 Medical E  | xaminer:Or                        | the basis<br>d manner: | of examina                     | ation and/   | or investiga            |                         |                        |                          |                         | the time, da              |                 |                  |                           |   | _        |
| ESES   | Š              | 29b Signature and title of cert   | fier                              |                        | 71                             |              |                         | 29                      |                        | se number                |                         |                           |                 |                  |                           | nth, Day, Year)                                   |          |
|  |                | XIVIS   | * H                               |                        | /                              | \            |                         |                         | O.C.                   | IVI. E.                  |                         |                           | June            | e 30, 20         | 700                       |   |          |
|  |                | 30. Name and address of pers  | son who don                       | pleted cau             | use of deat                    | h (Item 23   | <sup>a)</sup><br>111 Pe | nn Stre                 | et Rali                | timore                   | MD 212                  | 201                       |                 |                  |                           |   |          |
| \  |                | Susan Hogan MD.   |                                   |                        | -                              |              |                         |                         |                        |                          |                         |                           |                 |                  |                           |   |          |
| St<br>Regist   | ate            | 31. Date filed (Month, Day, Ye  | 3 200                             | 6                      | gistrar's                      | , 1          | 4                       | we                      | /                      |                          |                         |                           |                 |                  |                           |   |          |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July 1,2008 9:54рт м **Physician** Catherine White Mary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Civista Medical Center LaPlata Charles If Under 1 Year Hours Min April 1 8, 1931 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 75 Maryland 579-38-9572 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or itema 23s or 28a-f show traumatic event. In a Medical Examinating the notified at 1 ☐ Yes 3 No Port Tobacco MD Charles Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number or itema 23a or 7705 Zacary Road 20677 USA 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 Ê No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White 3 ☑ Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; any hilury or other traumatic event. The Medical Exagnes. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Insurance 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wilbur Jones Hazel Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret White/Daughter inlaw P.O. Box 423, Cobb Island, MD 20625 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State remetery crematory or other place)
Fort Lincoln Cem. 7/6/06 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Bladensburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00945 AREHART ECHOLS FUNERAL HOME, P.A. 19an Echa 211 ST. MARY'S AVE. LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARMHMIA **Physician** CARDIAC /Medical Due to (or as a consequence of): failu NE HEART Examiner 9ESTILE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physicien and the detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Bleeding gastrointesting 1 Yes 2 No 3 Probably 4 Junknown DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 SeNo 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier of au 2001 02 44436 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashvin J. Patel, MD, 102 Paul Mellon Court, Suite 102, Waldorf, MD 20602
31. Date filed (Month, Day, Year)
32. Highstrar's Signature ASTIV ...
31. Date filed (Month, Day, re State Registrar

|                            |  |                     | For Stete Registrar   | Please                      | State of Ma  |                             | d / Depa        |  | Health and                                     | -   |                              | _   | 2269   |
|----------------------------|--|---------------------|---|-----------------------------|--|-----------------------------|-----------------|--|--|---|------------------------------|---|--|
| c                          | A.   |                     |   | e (First, Middle, Las       | it)  |                             |                 |  |  | 2. Date of De   |                              |   | 3. Time of Death                                 |
|                            | Physici  |                     | BARBA   | RA J.                       | WILCOX   |                             |                 |  |  | JUNE  | 21                           | $2\overset{Year}{006}$  | 7:08 P M   |
|                            | /Medic   | land of             |   |                             | street and number)   |                             |                 | 4b. City, Town, o  | or Location of Dear                            |   |                              | unty of Death   |  |
| 1.                         | Examin   | er                  |   | GEORGE'S                    |  |                             |                 | CHEVER   | LY   |   | PRIN                         | CE GEO  | RGE'S  |
|                            | Funeral  |                     | 5. Social Security N  |                             |  | e (In yrs. I                | ast birthday)   | If Under 1 Year  | If Under 24 Hrs                                |   | th Years                     | 9. Birthp   | place (State or Foreign                          |
| 146                        | Director   |                     | 578-62-1<br>Usual Residence o   | 774                         | □M 2XF 6(  | )                           | Yrs.            | Months Days  | Hours Min                                      | SEPT.   | 8 194                        | 5 NEW   | YORK   |
|                            | nylanc<br>show   |                     | 10a. State  | 10b. County                 |  | 10c. City                   | , Town or Lo    | ocation  |  |   |                              | 1   | 10d. Inside City Limits  17 Yes 2 □ No           |
|                            | Ba-f   | cto                 | MD  | PRINCE (                    | GEORGE'S   | UPI                         | PER MA          | RLBORO   |  |   |                              |   |  |
|                            | 13 th  | Dire                | 10e. Street and Nu  |                             |  |                             |                 | 10f. Zip Code  |  |   |                              | of What Coul  | ntry?  |
|                            | 23a  | ra                  |   | RLTON CEN                   | TER DRIVE  |                             |                 | 20772  |  |   | U.S.A                        |   |  |
| 36                         | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other then "natural, or items 23a or 28a-f ehow or other traumatic event, the Medical Examinan multiplication at | by Funeral Director | 11. Marital Status  1 □ Never Marr  3 □ Widowed                                       | ried 2 Married              | 12. Was Decedent<br>Armed Forces?<br>1 ☐ Yes 2 ☑<br>If Yes, Give<br>Year or Dates: |                             |                 | Was Decedent of !<br>If Yes, specify Cub<br>1 ☐ Yes 212 No | Hispanic Origin? (Span, Mexican, Puer Specify: | Specify Yes or Note 1 (1) Note 1 |                              | Race - Americ<br>Black, White,<br>ecify: BI                         |  |
| 2-00                       | 72 hou<br>natura   |                     | (Spec   | 15. Decedent's Ec           | lucation<br>de completed)  |                             | 16a. Dece       | dent's Usual Occu  | pation<br>during most of wo                    | nrking  | 16b. Kind o                  | of Business/In  | dustry   |
| 21215-0036                 | 2 should be filed within and Mental Hygiene. is marked other then "surmatic event, the Mas   | Completed           | Elementary/Second 12th  | , , , ,                     | College (1-4or   | 5+)                         |                 | DO NOT use retire  | during most of wo                              |   | PRIV                         | ATE   |  |
| 9                          | al Hygie<br>t other  | Be                  |   | (First, Middle, Last)       |  |                             |                 |  |  | me (First, Middle   | , Maiden Sur                 | name)   |  |
| yla                        | Mental   | 안                   |   | O. LEWIS                    |  |                             | 1               |  | CLARA  | HARRIS  | 0:1                          |   | 0.43   |
| , Maryland                 | and 2 sh<br>salth and<br>n 27 is m   |                     | TANYA   | WILCOX/D                    |  |                             | 1270            | 08 MARLTO  | N CENTER                                       | DR. UPF   | ER MAR                       | LBORO,  | MD 20772   |
| Baltimore,                 | Pages 1<br>ent of He<br>ht: if item<br>ry or oth   |                     |   |                             | Removal from State   | C                           | emetery, cre    | osition (Name of<br>matory or other pla<br>ERANS CEM       | nce)<br>METERY 6/                              | 30/2006   |                              | on - City or To<br>ENHAM ,  | own, State<br>,MARYLAND                          |
| Baltin                     | permit. Pages 1 and 2<br>Department of Health a<br>important: if item 27 is<br>eny injury or other tra<br><u>pnce.</u>   |                     |   | uneral Service Licer        |  | 1                           |                 | 2. Name and Addre  |  | J. B. J   |                              |   |  |
|                            |  |                     | 23a. Part1. Enter   | the disease, or com         | plications that cause<br>one cause on each li                                      | d the death                 | n. Do not en    | ter the mode of dy   | ing, such as cardia                            | c or respiratory a  | irrest,                      |   | Approximate<br>Interval Between                  |
|                            | Physician  |                     | Immediate Cause   | (Final                      |  |                             |                 | r FAILURE  |  |   |                              |   | Onset and Death                                  |
| 1                          | /Medical   |                     | disease or condition resulting in death)  |                             | a. CONGE:  |                             |                 | L PALLONE  |  |   |                              |   |  |
|                            | Examiner   |                     |   |                             | ,  |                             |                 | IYOPATHY   |  |   |                              |   |  |
|                            |  | e                   | Sequentially list confidence if any, leading to in cause. Enter Und Cause (Disease of | onditions,<br>mmediate      | Due to (or as  | a consequ                   | uence of):      |  |  |   |                              |   |  |
|                            | uted<br>d<br>anslt   | 듄                   | Cause (Disease of<br>that initiated event   | erlying<br>r injury         | HYPER'   | TENSI                       | VE HEA          | ART DISEA  | SE   |   |                              |   |  |
| Ć.                         | be execuicien and burial-tran  | Examiner            | resulting in death)   | Last                        | Due to (or as  | a consequ                   | uence of):      |  |  |   |                              |   |  |
| 1760,                      | ite be executed<br>lysicien and<br>ne burial-translt   | cal                 |   | •                           | d  |                             |                 |  |  |   |                              |   |  |
| 68                         | certificate<br>iding physise as the  | Jed                 | IF FEMALE:  |                             |  |                             |                 |  |  |   |                              |   |  |
| P.O. Box                   | the death<br>the atter<br>ched for u   | Physician/Medi      | 23b. Was deceder in the past 12 1 Yes 2 9 Unknown                                     | months?                     | 23c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant a<br>9 ☐ Unknown            | 2 Fetal                     | I death 3[      | □Ectopic pregnand □ Other (specify) _                      | ey   |   | 23d.                         | Date of delive<br>Month   | ery<br>Day Year                                  |
|                            | ₽ B B  | by Pl               | Part II. Other signi  | ificant conditions          | ontributing to death t   | out not resi                | ulting in the u | inderlying cause gi  | ven in Part I.                                 | 23e. Did  | tobacco use                  | contribute to t   | he cause of death?                               |
| rds                        | w requires<br>been sign<br>should be   | ed b                | CHRO  | NIC RENAL                   | FAILURE  |                             |                 |  |  | ¥.  | Yes 2□N                      | o 3□Prot  | oably 4 Unknown                                  |
| Division of Vital Records, | The law re<br>sete has bee<br>page 2 sho   | Completed           |   |                             |  |                             |                 |  |  | 24a. Was<br>auto<br>perf<br>1 Yes   | s an 24                      | 4b. Were auto<br>prior to co<br>death?<br>1 \( \subseteq \text{Yes} | opsy findings available<br>impletion of cause of |
| tal                        | certifice<br>rector, p   | a)                  | 25. Was case refe   | erred to medicat            |  |                             |                 |  | 26. Place of De                                | ath (Check only   |                              | 72 103  | 2,0110   |
| >                          | Physicien:<br>this certific<br>rai director,   | To B                | examiner?<br>1 ☐ Yes 2 🖸  | 3 No                        | Hospital:  | ent 2 🔀                     | ER/Outpatie     | nt 3 DOA Ot  | thos   | Home 5 ☐ Res  |                              | Other (Specil   | fv)  |
| 0                          | g Ph<br>ler th   |                     | 27. Manner of Dea   |                             | 28a. Date of Inju<br>(Month, Da  | ury<br>av Year)             | 28b. Time o     | of 28c. Inju   |  | 28d. Describe   |                              |   | ,,   |
| <u>io</u>                  | E A B  | ate                 | 1 ∑Natural<br>2 ☐ Accident  | 5 Pending investigation     |  | .y . ou.,                   | mjory           |  | Yes 2 No                                       |   |                              |   |  |
| Divis                      | if or Attendent efter death Director:  | Certification:      | 3 Suicide<br>4 Homicide   | 6 Could not b<br>determined | e 28e. Place of In<br>building, e  | jury - At ho<br>tc. (Specif | ome, farm, st   | reet, factory, office                                      |  |   | (Street and Ni<br>wn, State) | umber or Rura   | al Route Number,                                 |
| _                          | To the Hospitai or A within 24 hours effer To the Funeral Director Completely filled in by   | Medical C           | 29a. Certifier<br>(Check only<br>one)   |                             | nysician: To the best<br>niner: On the basis of<br>and manner st                   | of examina                  |                 |  |  |   |                              |   |  |
|                            | To the within To the comple  | Me                  | 29b. Signature and  | d title of certifier        | An-  | 4                           | - 00            | 29c. Licen   | se number                                      |   | 29d. Date si                 | gned (Month,  | Day, Year)                                       |
|                            |  |                     | 1   | ear                         | 19 m   | ay                          | U.              | D281   | 195  |   | JUNE                         | 23,   | 2006   |
| f                          | (12)   |                     |   |                             | completed cause of   |                             |                 |  | 17 TARCO                                       | MADVIAN   | ID 2077                      |   |  |

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUL 0 3 2006

State of Maryland / Department of Health and Mental Hygiene For State Ragistra Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 11:08 **Physician** July 4, 2006 Phyllis Ann Welch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Mary's Lexington Park 46593 Valley Court, Apt. 9009 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🔀 F September 6.1944 District of Columbia 217-42-2766 61 Director Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits with the Maryland 10a State 10h Cough in than "naturel", or Items 23a or 28a-f show the Medical Examinar coust be notified at 1 ☐ Yes 2 📆 No Directo St. Mary's Lexington Park Maryland 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 46593 Valley Court Apt. 9009 20653 USA death ! Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than . College (1-4or 5+) Elementary/Secondary (0-12) Bus Driver School other o 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H tant: If Item 27 Is marked other Betty Irma Goldsborough Upton Eugene Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 46593 Valley Court Apt. 9009, Lexington Park, Maryland 20653 Charles Clark Welch / Son other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 Department of Important: If any injury or once. Evergreen Memorial Gardens July 8, 2006 Lexington Park, Maryland 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 21. Signature of Funeral Service Licensee Michael Kern Pardener 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischemic Heart Disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conscionance of) Examiner The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 X No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the et d be detached fo o 9□ Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan ate has t page 2 s autopsy performed? 1 □ Yes 2√√D√No Division of Vital To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home & Residence 6 Other (Specify) 1X Yes 2□No 2 ☐ ER/Outpatient 3 ☐ DOA P this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 XNatural 5 Pending investigation death. 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier adden D0050883 7/5/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11655 WINESUP 31. Date filed (Month, Day, Year) egistrar's Signature State JUL 1 0 2006 Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 22696

|   |               | 1- For State Certificate   | of Death   | Reg.                  | . No.                           | 4.400                                     |
|---|---------------|--|--|-----------------------|---------------------------------|---|
| Physic  |               | Decedent's Name (First, Middle,Last)   |  | 2. Date of Death      |                                 | 3. Time of Death                          |
| edical Exam   | iner          | Ralph Herndon White  |  | June 26, 20           |                                 | 1225 hrs                                  |
| k   |               | 4a. Facility Name (if not institution, give street and number)   | 4b. City, Town, or Location of Deat  | n                     | 4c. County of Death             | 1-  |
|   |               | 4715 Oglethorpe Street   | Riverdale  |                       | Prince George                   |   |
| Funeral<br>Director   |               | 5. Social Security Number 6. Sex 7 Age (In yrs. last birthday  | ) If Under 1 Year If Under 24Hr  Months Days Hours Mir   |                       | (MM/DD/YYYY) 9 Birtl<br>Foreign | 1   |
| Director  |               |  | Yrs.   | 03/14/1               | 1944 Co.                        | intry) DC                                 |
| ž.  |               | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo  | votion   |                       |                                 | 10d Inside City Limits                    |
| 0 W 2f  |               | MD Prince George's Riverdal  |  |                       |                                 | 1 X Yes 2 No                              |
| yland<br>I-f sh   | 혉             | 10e. Street and Number   |  | 140-                  | 635                             |   |
| e Mar<br>r 28a<br>ied at  | Director      |  | 10f. Zip Code  |                       | . Citizen of What Coun          | ,   |
| ith th<br>23a (   |               | 4715 Oglethorpe Street  11. Marital Status   12. Was Decedent Ever in U.S.   13.   | 20737  |                       | Jnited Stat                     |   |
| r death with the Maryland<br>or items 23a or 28a-f show any<br>must be notified at once.  | uneral        | 1 Never Married 2 Married Armed Forces?  | Was Decedent of Hispanic Origin? (S<br>If Yes, specify Cuban, Mexican, Puerto  |                       | 14. Race - Americ<br>White, etc | an Indian, Biack,                         |
| ter de  | ш             | 1 X Yes 2 No 3 Widowed 4 X Divorced If Yes, Give Year UNK  | Yes 2 X No specify:  |                       | Specify Whi                     | te  |
| urs af<br>tural'  | d b           | or Dates.  | dent's Usual Occupation (Give kind of  | work done             | 6b. Kind of Business/Ir         |   |
| 72 hou  | Completed     |  | g most of working life. DO NOT use ret   |                       |                                 | ,   |
| D36<br>thin ne.   | npl           | 12 Weld  | er   |                       | Unknown                         |   |
| 5-0<br>ed wi<br>fygie<br>other  | ပ္ပ           | 17. Father's Name (First, Middle, Last)  | 18.Mother's Name   | e (First, Middle, Mai | iden Surname)                   |   |
| MD 21215-0036 d 2 should be filed within 72 hours after this and Mental Hygiene. n 27 is marked other than "natural", tumatic event, the Medical Examiner.  | Be            | Herndon P. White   | Frances  | Isabelle              | Souder                          |   |
| 2 2 4 hould hould Me is ma  | 7             | 19a. Informant's Name/Relationship (Type, Print )  | iling Address (Street and Number or  | Rural Route Numbe     | er, City or Town, State,        | Zip Code)                                 |
| ME<br>nd 2 s<br>alth a<br>m 27  |               | Mark H. White / Son 854  | 8 Mervise Ct., No  |                       |                                 |   |
| more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Filed than Momental Hygiene. The filed provided that the "matural", or items 23a or 28a-f she wit. If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once |               |  | position (Name of cemetery,<br>r other place)  | Date 2                | Oc. Location - City or 1        | own State                                 |
|   |               | 4 Donation 5 Other Specify: Chesapes   | ake Crematory 07/  | 05/2006               | Beltsville,                     | , MD                                      |
| Baltimore, MD 21215-003 Bernit, Pages I and 2 should be filed within Department offsel and Montal Hygiene. In frem 27 is marked other It injury or other traumatic event, the Med   |               |  | 2 Name and Address of Facility<br>Thibadeau Mortuar  | v Service             | РΛ                              |   |
|   |               | M00956   | 933 Gist Ave., LL  | Silver                | Spring, MD                      | 20910                                     |
| Physician Medical   |               | 23a. Part I. Enter the disease, or complications that caused the death. Do not ent-<br>failure. List only one cause on each line.  | er the mode of dying, such as cardiac o  | r respiratory arrest, | , shock, or heart               | Approximate Interval<br>8etween Onset and |
| Examiner  |               | Immediate Cause (Final disease or condition resulting in death)  | isease   |                       |                                 | Death                                     |
|   |               | b book to for all a consequence or),   |  |                       |                                 |   |
|   | ner           | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  |  |                       |                                 |   |
|   | Examin        | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  Due to (or as a consequence of): |  |                       |                                 |   |
| uted<br>id<br>ansit   | EX            | events resulting in death) Last Due to (or as a consequence of):  d.   |  |                       |                                 |   |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after this There his certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit      | Medical       | UNPENDED AMENDED   |  |                       |                                 |   |
| 760, icate be physici the buri  | Mec           | IF FEMALE: 23c. If yes, outcome of pregnancy   |  |                       | 23d Date of delivery            |   |
| 687<br>ertific<br>ding p  |               | 23b. Was decedent pregnant in the past 12 months?  | Fetal death 3 Ectopic pregna   | ancy                  | Month Da                        | y Year                                    |
| Box 68;<br>death certiff<br>the attending   | sician        | 1 Yes 2 No 9 Unknown Pregnant at time of 5 Unknown   | Other (Specify)  |                       |                                 |   |
| O. B<br>tribe de<br>by the  | Phys          | Part II. Other significant conditions contributing to death but not resulting in the   | e underlying cause given in Part I   | 23e Did tobar         | cco use contribute to th        | e cause of death?                         |
| P.O. es that the  | by            | S S S S S S S S S S S S S S S S S S S  | o and onlying cause given in hart.   |                       | 2 No 3 Proba                    |   |
| Records, P The law requires t ficate has been sign,   | Completed     |  |  | 24a. Was an           |                                 | psy findings available                    |
| cor<br>law ra<br>has b  | ıρle          |  |  | autopsy<br>performe   | prior to co                     | mpletion of cause of                      |
| tal Recian: The certificate ector, page   | Con           |  |  | 1 Yes 2 ₩             |                                 | 2 No                                      |
| ician:<br>certifi<br>rector,  | Be            | 25. Was case referred to medical examiner?   | 26.Place of Death (Check   |                       |                                 |   |
| of Vital ng Physician: After this certi   | 70            | 1 Yes 2 No   |  |                       | sidence 6 🗸 Other:              | Scene                                     |
| ding<br>h. Aft  | on:           | 27 Manner of Death  1  Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time  | of Injury 28c. Injury at Work?   | 28d. Describe how     | injury occurred                 |   |
| Sional Atter  | cat           | 2 Accident Investigation 28e. Place of Injury - At home, farm, s   |  | 206 1 15 (01          | 4 (1)                           | 15  |
| Division  Hospital or Attendir 24 hours after death. Funeral Director: A  | Certification | determined (Specific)  | rreet, ractory, office building, etc.  | or Town, State        | et and Number or Rura<br>e)     | I Route Number, City                      |
| Hospital<br>24 hours<br>Funeral   |               | 29a. Certifier   | curred at the time, date and place, and  | due to the source(s)  | ) and manner or storte          | d   |
| To the F<br>within 2.<br>To the F<br>complete   | edical        | one) 2 Medical Examiner: On the basis of examination and/or investi  |  |                       |                                 |   |
| To COT  | Me            | and manner stated.  29b. Signature and title of certifier  | 29c. License number  | 29                    | 9d Date signed (Monti           | h, Day, Year)                             |
| 4+1   |               | aust '   | O.C.M.E.   | J                     | une 30, 2006                    |   |
|   |               | 30. Name and address of person who completed cause of death (Item 23a)   |  |                       |                                 |   |
|   |               | • =   • • • • •  | Street, Baltimore, MD 21201  | l                     |                                 |   |
|   | tate          | 31. Date filed (Months Pay; Year) 5 2006 32. Registrar's Signature   | marks  |                       |                                 |   |
| Renis   |               | APPAR 12 A 7 111 111 PT F A A A A A A A A A A A A A A A A A A  | NAME OF TAXABLE PARTY O |                       |                                 |   |

|   |                      | For   |                                     |                                | and / Depa                          | artment                                 | t of H                   | ealth a             | and Mo      | -                              | _  | nne.  | 226                           | 0.7       |
|---|----------------------|---|-------------------------------------|--------------------------------|-------------------------------------|---|--------------------------|---------------------|-------------|--------------------------------|--|---|-------------------------------|-----------|
|   |                      | 1 - State<br>Registrar  |                                     |                                | Ce                                  | rtificate                               | e of L                   | Death               |             |                                | Reg. No.   | 00  | 440                           | 21        |
| Physic  | ian                  | Decedent's Name (First, Middle  |                                     | 101 1                          |                                     |   |                          |                     |             | 2. Date of De.<br>Month        | Day  | Year  | 3. Time of Do                 | eath<br>M |
| /Med  | ical                 | Elizabeth   |                                     |                                | .d                                  | 4h Cihi                                 | Tour or                  | Location o          | of Dooth    | July                           | 1, 200   | y of Death                                  | 4:15P                         | 101       |
| Exami   | ner                  | 4a. Facility Name (If not institution Wilson Health   |                                     |                                |                                     |   |                          | sburg               |             |                                | Monta  |   | .7                            |           |
| Funeral   | 1000                 | 5. Social Security Number   | 6. Sex                              |                                | rs. last birthday)                  | If Under                                | 1 Year                   | If Under a          | 24 Hrs.     | 8. Date of Birt                |  | 9. Birth                                    | olace (State or F             | Foreign   |
| Director  |                      | 215-16-9342   | 1 ☐ M 2 🟋 F                         | 84                             | Yrs.                                | Months                                  | Days                     | Hours               | Min.        | 8. Date of Bird<br>Mov • 18    | , Ye 1921  | Ma  | ryland                        |           |
| <b>b</b>  |                      | Usual Residence of Decedent   |                                     | 100                            | City, Town or Lo                    | nation                                  |                          |                     |             |                                |  |   | 10d. Inside City              | Limite    |
| aryla<br>ehov   | 7                    | 10a. State 10b. County  | ~ ~ ~ ~ ****                        |                                | **                                  |   |                          |                     |             |                                |  |   | 1 Tes 2                       |           |
| h the Maryland<br>r 28a-1 ehow  | Director             | Maryland Monts  10e. Street and Number  | gomery                              |                                | Damascus                            | 10f. Zip                                | Code                     |                     |             |                                | 10g. Citizen of  | What Cou                                    |                               | Λ         |
| with<br>Ba or   | 0                    | 10805 Kingste   | ead Road                            |                                |                                     | 101. 2.1                                |                          | 872                 |             |                                | U.S.   |   | ,                             |           |
| death   | Funeral              | 11. Marital Status  | 12. Was De                          | cedent Ever i                  | n U.S. 13.                          | Was Deced                               |                          | -                   | gin? (Spec  | crfy Yes or No<br>Rican, etc.) |  | ce - Ameri                                  |                               |           |
| or ite  | F                    | 1 ☐ Never Married 2 ☐ Marr  | ried 1 Yes                          | Forces?<br>2 No<br>Sive X      |                                     |   |                          | n, Mexican Specify: | і, Риепо Р  | rican, etc.)                   |  | ick, White,                                 | etc.                          |           |
| 15-UU36 72 hours after death with the Maryland "naturel; or items 23a or 28s-1 show   | d by                 | 3 XWidowed 4 □ Divorced   | Year or                             | Dates:                         |                                     | 1□ Yes 2                                | X                        | эроспу.             |             |                                | Speci  | WII.  |                               |           |
|   | Completed            | 15. Deceden<br>(Specify only highe  | t's Education<br>st grade completed | 1)                             | (Give                               | dent's Usua<br>kind of wor<br>DO NOT us | rk done a                | during most         | t of workin | ng                             | 16b. Kind of E   | Business/In                                 | dustry                        |           |
| within 72 ene.  | dmo                  | Elementary/Secondary (0-12)   | College                             | (1-4or 5+)                     |                                     | les                                     | so rotirou,              | ,                   |             |                                | Advert   | ising                                       | 2                             |           |
| N OBS   | Be Co                | 17. Father's Name (First, Middle,   | Last)                               |                                | sa.                                 | res                                     |                          | 18. Mothe           | r's Name    | (First, Middle,                | Maiden Suma  |   | <b>-</b>                      |           |
| <u>−</u> 2000€  | To B                 | John Michael (  | Gorney                              |                                |                                     |   |                          | Eli.                | zabet       | th Ann                         | Mikula   |   |                               |           |
| Taryla 2 should and Men 1s marke  |                      | 19a. Informant's Name/Relations   | hip (Type, Print)                   |                                | 19b. Maili                          | ng Address                              | (Street a                | and Numbe           | er or Rural | Route Numbe                    | er, City or Town   | , State, Zip                                | Code)                         |           |
| N -   | ł                    | Patricia A. Sto   | ovall - D                           |                                |                                     |   |                          | k Dri               |             |                                |  |   |                               | 0886      |
| Baltimore, permit. Pages 1 ar Department of Hea Important: if Item any injury or othe one.  |                      | 20a. Method of Disposition 1   Burial 2 □ Cremation   | 3 Removal from                      | n State                        | b. Place of Dispo<br>cemetery, crei | matory or or                            | ther place               |                     |             | ate                            | 20c. Location  | •   |                               |           |
| nit. Pa<br>artmen<br>ortant:<br>injury  |                      | 4 □ Dorration 5 □ Other (S  |                                     | F                              | All Soul                            |   |                          |                     | /10/        |                                |  |   | Maryla                        | nd        |
| Departmin   |                      | 21. Signature of Funeral Pervice  | Z.                                  | illia                          | ms) M                               | olesw                                   | a Addres<br>orth<br>Ride | -Will<br>Be Roa     | iams        | P.A.,                          | Funera   | l Hom<br>vland                              | e<br>2087                     | 2         |
|   |                      | 23a. Part1. Enter the disease, or shock, or heart failure. List   | complications that                  | t caused the c                 |                                     |   |                          |                     |             |                                |  |   | Approximate<br>Interval Betwe | en        |
| Physician   |                      | Immediate Cause (Final disease or condition   | A                                   | lexis                          | etic.                               | Dar                                     | le                       | ere                 |             |                                |  | 6   | Ponset and De                 |           |
| /Medical<br>Examiner  |                      | resulting in death)   | Due t                               | o (or as a con                 | sequence of):                       |   |                          |                     | , /         | rei                            |  |   |                               |           |
| LAGITITICI  |                      | Sequentially list conditions,   | b. Due t                            | o Joras a con                  | o ger                               | ul                                      |                          | CE                  | rer         | 121                            |  |   |                               |           |
| ted<br>nsit   | Examiner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | < □                                 | 0,000.000                      | 300,000 01/.                        |   |                          |                     |             |                                |  |   |                               |           |
| 760,<br>te be executed<br>ysician and<br>e burial-transit   | Exal                 | that initiated events<br>resulting in death) Last   | C. Due t                            | o (or as a con                 | sequence of):                       |   |                          |                     |             |                                |  |   |                               |           |
|   | cal                  |   | d                                   |                                |                                     |   |                          |                     |             |                                |  |   |                               |           |
| Records, P.O. Box 68. The law requires that the death certificat the has been signed by the attending phy page 2 should be detached for use as this | Med                  | IF FEMALE:  |                                     |                                |                                     |   |                          |                     |             |                                |  |   |                               |           |
| BOX<br>bath cer<br>attendir<br>for use  | lan/Med              | 23b. Was decedent pregnant in the past 12 months?   | 1 Live                              | outcome of pre<br>birth 2 🗆 F  | Fetel death 3                       | Ectopic pr                              |                          |                     |             |                                |  | ate of delive                               | ery<br>Day Ye                 | ar        |
| the deady the a   | Completed by Physici | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown   | 4∐Pre<br>9□Uni                      | gnant at time<br>known         | of death 5                          | Other (sp                               | ecrfy)                   |                     |             |                                |  |   | ,                             |           |
| 15, P.O. I  | Ph                   | Part II. Other significant condition  | ons contributing to                 | death but not                  | resulting in the u                  | inderlying c                            | ause give                | en in Part I.       |             | 23e. Did t                     | obacco use gor   | tribute to t                                | he cause of dea               | ath?      |
| ds,<br>uires<br>uires<br>ld be  | d b                  | arone   | yours.                              | Licesi                         | Vec le                              | rek                                     | in                       | res                 |             | 10                             | res 2 🗹 No   | 3 🗆 Prot                                    | oably 4 🗆 Uni                 | known     |
| Records,<br>he law requires t<br>s has been signe<br>ge 2 should be o   | lete                 | Thromb  | basto                               | pehr                           | ia                                  |   |                          |                     |             | 24a. Was                       |  | Were auto                                   | psy findings av               | ailable   |
| The lav   | E O                  | Chemis  | also                                | mi                             | al .                                |   |                          |                     |             | autor<br>perfo                 | rmed)/   | prior to co<br>death?<br>1 \( \text{Yes} \) | mpletion of cau               | ise of    |
|   | BeC                  | 25. Was case referred to medica   |                                     | ~~~                            |                                     |   |                          | 26. Place           | of Death    | Check only o                   | The state of the s | 103   | 20,110                        | -         |
|   | To                   | examiner?<br>1 🗆 Yes 2 🖭 No   | Hospital: 1 [                       | Inpatient                      | 2 ER/Outpatier                      | nt 3 DC                                 | Othe Othe                | 9r: 4 12 Nu         | rsing Hom   | ne 5 🗆 Resid                   | dence 6 🗆 Ot   | her (Specia                                 | fy)                           |           |
| ing ing   | ino<br>ii            | 27. Manuer of Death<br>1 ☑Natural 5 ☐ Pendir  | ng (Mo                              | e of Injury<br>onth, Day Yea   | r) 28b. Time o                      |   | Bc. Injury<br>Work       |                     |             | 28d. Describe I                | now injury occu  | rred  |                               |           |
| ision ( ttending F death. ctor: After y the funer   | cat                  | 2 Accident Investi  | not be 200 Blo                      | as of Injury                   | At home, farm, st                   | M                                       |                          | Yes 2 🔲             |             | Of Location (                  | Street and Alum  | bor or Pur                                  | al Route Numbe                | 0.0       |
| Division  Hospital or Attency 24 hours after death Funeral Director:  | Certification:       | 4 ☐ Homicide determ   |                                     | Iding, etc. (Sp                |                                     | reet, ractory                           | r, onice                 |                     | -           | City or Tov                    | vn, State)   | 001 01 11016                                | 31 710010 14011100            | ,,        |
| spite<br>hours<br>ineral<br>y filled  |                      | 29a. Certifier 1 Certifyii  | ng Physician: To t                  | he best of my                  | knowledge, deat                     | h occurred                              | at the tim               | ne, date an         | d place, a  | and due to the                 | cause(s) and m   | anner as s                                  | tated.                        |           |
| To the Hospitel or<br>within 24 hours after<br>To the Funeral Dir<br>completely filled in   | ledical              | one)  |                                     | basis of exam<br>anner stated. | nination and/or in                  |   |                          |                     | th occurre  |                                |  |   |                               |           |
| To the within 2 To the complet  | Σ                    | 29b. Signature and title of certifie  | /                                   |                                | ()                                  |   |                          | number              | /(-         |                                | 29d. Date sign   | ed (Month,                                  | Day, Year)                    |           |
|   |                      | 1 / Rabe  |                                     |                                |                                     |   |                          | 411                 | 0           | (163                           | vecla (  | 1/0   | KUG                           |           |
| 10  |                      | 30. Name and address of person  | TOIR                                | SCH                            | (Item 23a) (Type,                   | Print)                                  | 4                        | ZH.                 | 477         | TERS                           | Bur  | SiM   | 1500                          | 777       |
| S<br>Regis  | tate<br>trar         | 31. Date filed (Month, Day, Year)   | 0 6 2006                            |                                | ignature                            | do                                      | do                       |                     |             |                                |  | ,   |                               |           |
|   |                      |   |                                     | -                              |                                     | 1                                       |                          |                     |             |                                |  |   |                               |           |

Please Type or Print in Black Indelible Ink 06-04695 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Jeremy Wechsler State Certificate of Death Reg No. Registrar 2 Date of Death Decedent's Name (First, Middle,Last) Physician/ Year Dav Month 1057 hrs July 4, 2006 **Medical Examiner** JEREMY ANDREW WECHSLER 4a Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Hyattsville 8214 18th Avenue If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** oreian Davs Hours Min Months Country) MARYLAND Director FEBRUARY 3. 1984 1 X M 22 218-25-2537 Usual Residence of Decedent 10d Inside City Limits Oc City, Town or Location Yes 2 X No s 23a or 28a-f show notified at once. MARYLAND MONTGOMERY SILVER SPRING death with the Maryland Director Og Citizen of What Country? 10e Street and Number 10f. Zip Code 13900 CASTLE BOULEVARD #203 20904 U.S.A. Funeral 14 Race - American Indian, Black 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 X Never Married 2 X No Ves or Yes 2 X No specify WHITE Divorced Specify If Yes. Give Year "uaturaf", þ Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) marked other than " MD 21215-0036 RESTAURANT ASSOCIATE FOOD SERVICE 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HERBERT WECHSLER GALE ILENE BENNOF of Health and Mental 19a Informant's Name/Relationship (Type, Print ) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is 2909 CHAPEL VIEW DRIVE, SILVER SPRING, MARYLAND 20904 KURT WECHSLER - GRANDFATHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Removal from State Cremation 3 MOUNT LEBANON CEMETERY JULY 10,2006 ADELPHI, MARYLAND Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Servi & Litensee HINES-RINALDI FUNERAL HOME. INC 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Part I Ente **Physician** failure List only one cause on each line Between Onset and Death /Medical Drowning Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause Enter Underlying Cause Due to (or as a consequence of): events resulting in death) Last and hysician/Medical X UNPENDED AMENDED attending physician for use as the burial item#23a,27,28a-f,perME,g858.8/14/06 TT Box 68760, 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions P.O. ģ Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 certificate 26 Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Division of Vital Be Hospital. 1 Other<sub>4</sub> DOA Nursing Home 5 Residence 6 V Other Scene Inpatient 2 ER/Outpatient 3 ၀ ✓ Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death Certification Driver of auto swept away during Yes 2 X Natural Pending Fnd 7/4/2006 unk the flash flood Investigation X Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Northwest branch of Potomac River Prince George's MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide within 24 hours a. To the Funeral L determined (Specify) Water Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d Date signed (Month, Day, Year) 29b Signature and title of cert 29c License number July 5, 2006 O.C.M.E. 30. Name and address of person Jack Titus MD Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Ga) State 2 2008 Registrar

DHMH 17 Rev 1/2001 OCME 2006 06-04545 Fre

# Please Type or Print in Black Indelible Ink

| eddie Waller  |   | State of Maryland / Departm   |               |   | Mental Hy                             |                            | g. No.                         | 106 2260   |  |
|---|---|---|---------------|---|---------------------------------------|----------------------------|--------------------------------|--|--|
| Physicia  | n/  | Decedent's Name (First, Middle, Last)   | _             |   |                                       | Date of Deat     Month     | Day Year                       | 3 Time of Death 2133 hrs                                       |  |
| edical Examir   |   | Freddie Thomas Waller  4a Facility Name (if not institution, give street and number)  | 4             | City, Town, or L                          | ocation of Death                      | June 28, 2                 | 4c. County of                  |  |  |
| )   |   | Dorchester General Hospital   |               | Cambridge                                 |                                       |                            | Dorchest                       |  |  |
| Funeral<br>Director   |   | 5. Social Security Number 6. Sex 7. Age (In yrs. last bin 215–38–1663 1X M 2 F 66   | thday)<br>Yrs | If Under 1 Year<br>Months Days            | If Under 24Hrs Hours Min.             | 8. Date of Bird            | `                              | 9. Birthplace (State or<br>Foreign Maryland<br>Country)        |  |
| ану   | -   | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town   | or Locatio    | in .                                      |                                       |                            |                                | 10d. Inside City Limits  |  |
| ž   | Ļ   | Maryland Dorchester Ell   | liott         | Island                                    |                                       |                            |                                | 1 Yes 2 X No   |  |
| larylar<br>8a-f s<br>at on  | Director  | 10e. Street and Number  |               | 10f Zip Code                              |                                       | 10                         | g. Citizen of Wha              | at Country?  |  |
| ith the Maryland 23a or 28a-f show  |   | 2362 Wharf Road   |               | 21869                                     | 17, 27                                |                            | USA                            | <u> </u>   |  |
| death with the Maryland ritems 23a or 28a-f she nust be notified at once  | Funeral   | 11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No   |               | Decedent of Hisp<br>s, specify Cuban,     |                                       |                            | 14 Race -<br>White,            | - American Indian, Black,<br>etc.                              |  |
| L 9 -   | by F  | Wildowed 4 Divorced If Yes, Give Year 1962-1982   | 1 🗌           | Yes 2X No                                 | specify.                              |                            | Specify:                       | White  |  |
| hours after 'natural'', o   | edt   | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)                         |               | s Usual Occupation<br>st of working life. |                                       |                            | 16b. Kind of Bus               | iness/Industry   |  |
| 5-0036 led within 72 hours afte Hygiene other than "natural"; the Medical Examiner  | 9 Elementary/Secondary (0-12)  15. Decedent's Education (Specify only nignest grade completed)  16. Decedent's Education (Specify only nignest grade completed)  16. Decedent's Education (Specify only nignest grade completed)  16. Decedent's Education (Specify only nignest grade completed)  16. Nind of Bus during most of working life. DO NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname) |   |               |   |                                       |                            |                                |  |  |
| D 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than natic event, the Medica   |   | 17. Father's Name (First, Middle, Last)   |               | 1   |                                       |                            | Maiden Surname)                |  |  |
| Z 2 9 2 3   | To Be   | Woodrow Thomas Waller  19a Informant's Name/Relationship (Type, Print)  19  | b. Mailing    | Address (Street                           |                                       | irginia<br>Rural Route Num |                                | , State, Zip Code)   |  |
|   | -   |   | _             |   |                                       |                            |                                | MD 21804   |  |
| re, M<br>1 and 2<br>Health<br>fitem 2   | Ì   | 20a. Method of Disposition 20b Place  |               | ion (Name of cem                          |                                       | Date                       | 20c. Location - 0              | City or Town, State  |  |
| Pages<br>nent of<br>ant: 1  |   | A Bullar 2 Cremation 3 Kemova nom state   | terans        | Cemetery                                  |                                       | 0/2006                     |                                | Maryland   |  |
| Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumating.  |   | 21 Signature of Funeral Service (icensee  | 22. Na<br>Ze. | ame and Address<br>ller Fun<br>6 Main S   | of Facility<br>eral Hom               | ne, P. O                   | . Box 20                       | )7   |  |
| Physician   | A   | 23a. Part I. Enter the disease, or complications that caused the death. Do n  | ot enter the  | b Main S<br>e mode of dying, s            | treet, E                              | ast New                    | Market,<br>est, shock, or hear | MD 21631 rt Approximate Interval                               |  |
| /Medical  |   | failure List only one cause on each fine.  Immediate Cause (Final disease a Atherosclerotic Cardiovascu                                   |               |   |                                       |                            |                                | Between Onset and<br>Death                                     |  |
| xaminer   |   | or condition resulting in death)  Due to (or as a consequence of):  |               |   |                                       |                            |                                |  |  |
|   | <u>ا</u>  | Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):   |               |   |                                       |                            |                                |  |  |
|   | Examiner  | (Disease or injury that initiated   |               |   |                                       |                            |                                |  |  |
| ecuted<br>and<br>transit  |   | events resulting in death) Last  Due to (or as a consequence of)  d   |               |   |                                       |                            |                                |  |  |
| O,<br>e be exec<br>ysician al<br>burial - t   | ledical   | UNPENDED X AMENDED Amend #5 Per   | FH C          | 358 8/17/06                               | 5 JH                                  |                            |                                |  |  |
| Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi |   | IF FEMALE. 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy  |               | al death 3                                | Ectopic pregna                        | incy                       | 23d Date of o                  | delivery<br>Day Year   |  |
| Box 6876<br>e death certificate<br>the attending phy<br>ed for use as the l   | Physician/N   | 1 Ves 2 Ne 0 Holosom  | - =           | er (Specify)                              |                                       |                            |                                |  |  |
| b. Bc<br>the dea  | Phys  | Part II. Other significant conditions contributing to death but not resulting   | na in the u   | nderlying cause g                         | ven in Part I.                        | 23e. Did to                | bacco use contrib              | oute to the cause of death?                                    |  |
| , P.O. res that the signed by be detach   | þ   | 3   | J             |   |                                       | 1 Yes                      | 2 No 3                         | Probably 4 🗸 Unknown   |  |
| rds,<br>require<br>been si  | Completed   |   |               |   |                                       | 24a. Was autop             |                                | Vere autopsy findings available from to completion of cause of |  |
| ecol<br>he law<br>ite has   | duc   |   |               |   |                                       |                            | med? de                        | eath?  Yes 2 No  |  |
|   | യ   | 25. Was case referred to medical  |               |   | of Death (Check                       | S                          |                                |  |  |
| Vita<br>hysici<br>this c  | To B  | examiner?  1  Yes 2 No Hospital: 1 Inpatient 2  ER/C  |               | 5 DOA                                     |                                       |                            | Residence 6                    | Other:   |  |
| n of  |   | 27. Manner of Death  28a Date of Injury (Month, Day, Year)  Pending  28b.   | Time of In    |   | y at Work?<br>es 2 No                 | 28d Describe               | now injury occurre             | ď  |  |
| Siol<br>Attender<br>r death<br>ector:<br>by the   | icati   | 2 Accident Investigation 28e, Place of Injury - At home, 1  | farm, stree   |   | 1-ment                                | 28f. Location (S           | Street and Number              | er or Rural Route Number, City                                 |  |
| Div<br>pital or<br>ours affe<br>eral Dir<br>filled in   | Certification:  | 3 Suicide 6 Could not be determined (Specify)   |               |   |                                       | or Town, S                 | tate)                          |  |  |
| Division of Vital   To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certificompletely filled in by the funeral director.              | edical C  | 29a Certifier (Check only one) Certifying Physician: To the best of my knowledge, de Medical Examiner: On the basis of examination and/or | eath occurr   | red at the time, dar                      | te and place, and<br>death occurred a | due to the caus            | e(s) and manner a              | as started<br>ue to the cause(s)                               |  |
| To t<br>To t  | Med   | and manner stated  29b. Signature and title of certifier  |               | 29c License                               |                                       |                            |                                | ed (Month, Day, Year)  |  |
|   |   | aue D   |               | 0.0.1                                     | <b>Л.</b> Е.                          |                            | June 29, 20                    | 106  |  |
|   |   | 30 Name and address of person who completed cause of death (Item 23a)   |               |   |                                       |                            | <u> </u>                       |  |  |
|   |   | Ana Rubio MD. Assistant Medical Examiner 111  | Penn S        | treet, Baltimo                            | re, MD 2120                           | 1                          |                                |  |  |
| S<br>Regis  | tate<br>trar  | 31 Date filed (Month, Day, Year)  JUN 3 0 2006  | ha            | ES.                                       |                                       |                            |                                |  |  |
| DHMH 17 Rev 1/2   |   | 0   | RIGINAL       |   |                                       |                            |                                |  |  |

DHMH 17 Rev 1/2001 OCME 2006

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                            |  | •                 | For<br>State<br>Registrar  | State of Marylan                                    | Certificate of Deal  | th   | Reg. No.   |
|----------------------------|--|-------------------|--|---|--|--|--|
|                            |  |                   | 1. Decedent's Name (First, Middle, Last)                                   |   |  | 2. Date of Da<br>Month                                     | Day Year   |
|                            | Physici<br>/Medic  |                   | GLENDA 1   | ANDERSO   | N  | ゴットイ   | 16 2006 12 13 PM   |
| Ž.                         | Examin   |                   | 4a. Facility Name (If not institution, give s                              | 3.4   | 4b. City, Town, or Location  |  | 4c. County of Death  |
|                            |  | -9.               | UNIVERSITY OF MARY  5. Social Security Number 6. Sex                       |   |  | der 24 Hrs. 8. Date of Birt                                | h 9. Birthplace (State or Foreign                                      |
|                            | Funeral<br>Director  |                   | 2/3 - 50 - 2986  | M 20 F 72   | Yrs. Months Days Hour  |  | y Year) Country) 4d  |
|                            | land<br>ow   |                   | 10a. State 10b. County   | 10c. City   | , Town or Location   |  | 10d. Inside City Limits  |
|                            | Man,   | tor               | Md N/A   | B   | altimore   |  | 1 Yes 2 No   |
|                            | or 28  | )ire              | 10e. Street and Number   |   | 10f. Zip Code  |  | 10g. Citizen of What Country?  |
|                            | 23a  | Funeral Director  | 2125 W. Baltin   |   | 2122   | 3  | USA  |
|                            | item<br>item   | nue               | 11. Marital Status  1 Never Married Married                                | 2. Was Decedent Ever in U.<br>Armed Forces?         | S. 13. Was Decedent of Hispanic<br>II Yes, specify Cuban, Mex  | : Origin? (Specify Yes or No<br>rican, Puerto Rican, etc.) | <ul> <li>14. Race - American Indian,<br/>Black, White, etc.</li> </ul> |
| 21215-0036                 | be filed within 72 hours after deeth with the Maryland stal Hygiene. d other then "naturel", or iteme 23a or 28e-f ehow event, the Modical Examiner must be maillied at                          | by                | 3 Widowed 4 Divorced   | 1 □Yes 2 No<br>If Yes, Give<br>Year or Dates:       | 1 ☐ Yes 2 No Spec  | city:  | Specify: Black   |
| <u>7</u>                   | "natu  | Completed         | 15. Decedent's Educ<br>(Specify only highest grade                         | cation<br>completed)                                | <ol> <li>Decedent's Usual Occupation<br/>(Give kind of work done during n<br/>life. DO NOT use retired)</li> </ol> | most of working  | 16b. Kind of Business/Industry   |
| 7                          | withir<br>ene.<br>then   | d Lic             | Elementary/Secondary (0-12)  | College (1-4or 5+)                                  | Secretary  |  | ENOEM Prait Library  |
| S                          | ntal Hygie<br>od other   |                   | 17. Father's Name (First, Middle, Last)                                    |   |  | other's Name (First, Middle,                               |  |
| lan<br>I                   | should be filed within nd Mental Hygiene. marked other then imatic event, Ite M  | To Be             | Clarence H.  | orsey   | Co   | arrie SM   | ith  |
| Maryland                   | and A  |                   | 19a. Informant's Name/Relationship (Type                                   |   | 19b. Mailing Address (Street and Nur   | mber or Rural Route Number                                 | er, City or Town, State, Zip Code)                                     |
|                            | and and mark   |                   | James Anderson   | Husband   |  | more st Bo   |  |
| Baltimore,                 | Pages 1<br>nent of H<br>int: If Ite<br>iry or oth  |                   | 20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Re                |   | lace of Disposition (Name of emetery, crematory or other place)  | Date   | 20c. Location - City or Town, State                                    |
| Ē                          | t. Partmen   | 1 4               | 4 ☐ Donation 5 ☐ Other (Specify)   | Cro   | winsville VA. Cem.   | 1/21/06  | Crownsville Md   |
| Bal                        | permit. Pages 1 and 2 should<br>Department of Health and Men<br>Important: If Item 27 is marke<br>eny Injury or other traumatic<br>eng E.E.  |                   | 21. Signature of Juneral Service Lic Service                               |   | 5246 Reister   | acinty C MELALLICITO                                       | - Harris Funeral Home  |
|                            | 9  |                   | 23a. Part1 Enter the disease, or compli                                    | cations that caused the deatl                       |  |  | rrest Approximate  |
|                            | Dhusisian  |                   | sbeck, or heart failure. List only on<br>Immediate Cause (Final            | 0   | all HIDERT   | 100 210  | Interval Between<br>Onset and Death                                    |
| )                          | Physician<br>/Medical  |                   | disease or condition resulting in death)                                   | Due to (or as a conseq                              | LEY HYPERT   | ENZION   |  |
|                            | Examiner   |                   | Sequentially list conditions   |   | ,  |  |  |
| 1                          | D #  | ner               | ii any, leading to immediate cause. Enter Underlying                       | Due to (or as a conseq                              | uence off.   |  |  |
| 19                         | ecute<br>and<br>trans  | Examiner          | Cause (Disease or injury that initiated events resulting in death) Last    | . Due to for an analysis                            |  |  |  |
| 60,                        | be ex<br>icien<br>burial   |                   |  | Due to (or as a conseq                              | dence or):   |  |  |
| 68760,                     | rificate be executed og physicien and as the burial-transit  | dic               |  |   |  |  |  |
|                            | nding<br>use a   | Physician/Medical | IF FEMALE:<br>23b. Was decedent pregnant                                   | 3c. If yes, outcome of pregna                       |  |  | 23d. Date of delivery  |
| . Box                      | Attending Physiclen: The law requires that the death cer death. cleath. sctor: After this certificate has been signed by the attendir by the funeral director, page 2 should be detached for use | icia              | in the past 12 months?<br>1 □ Yes 2⊠No                                     | 1 Live birth 2 Feta<br>4 Pregnant at time of d      |  |  | Month Day Year   |
| P.O.                       | at the<br>by th  | hys               | 9 🗆 Unknown  | 9□ Unknown  | 11   |  |  |
| <u>"</u>                   | res thi<br>igned<br>be de  | by                | Part II. Other significant conditions con                                  | tributing to death but not res                      | ulting in the underlying cause given in Pa   | 1  | obacco use contribute to the cause of death?                           |
| ord                        | w require<br>been sig  | ted               |  |   |  |  | Yes 2 No 3 Probably 4 Munknown   |
| 3ec                        | e taw<br>has b   | Completed         |  |   |  | 24a. Was   |  |
| al                         | n: Th<br>ficate<br>f. pag  |                   |  |   |  | 1 ☐ Yes  | 2. No 1 ☐ Yes 2 ☐ No   |
| ₹                          | sicle:<br>certi  | o Be              | 25. Was case referred to medical examiner?  1 Yes 2 No                     | lospital: 1. Inpatient 2                            | Other  | Place of Death (Check only                                 | dence 6 ☐Other (Specify)   |
| o                          | g Phy<br>er this<br>eral d   | n: To             | 27. Manner of Death  | 28a. Date of Injury<br>(Month, Day Year)            | 28b. Time of 28c. Injury at  |  | how injury occurred  |
| ion                        | ath.<br>r: Aft   | atio              | 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation                          | (Month, Day rear)                                   | Injury Work?<br>M 1 ☐ Yes 2  | 2 □No  |  |
| Division of Vital Records, | F 9 F C  | Certification:    | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At he building, etc. (Specif | ome, larm, street, factory, office   | 28l. Location (<br>City or To                              | Street and Number or Rural Route Number,<br>wn, State)                 |
|                            | urs al   |                   | On Carthe A Picarth in the   |   |  |  |  |
|                            | To the Hospitel of within 24 hours af To the Funeral D completely filled in  | edical            | 29a. Certifier 1 Certifying Physical Check only 2 Medical Exemination one) | ner: On the basis of examina<br>and manner stated.  | wledge, death occurred at the time, date<br>tion and/or investigation, in my opinion,                              | death occurred at the time,                                | date and place, and due to the cause(s)                                |
|                            | vithin<br>Fo the   | ¥e                | 29b. Signature and title of certifier                                      |   | 29c. License numb  | ber  | 29d. Date signed (Month, Day, Year)                                    |
|                            | ,- , F 0   |                   | 1 4000   |   | 1741   | 6  | Tury 16 2006   |
|                            | 2  |                   | 30. Name and address of person who   | ed cause of death (Iter                             | n 23a) (Type, Print)   |  | BALTIMORE, MD  |
| _                          | T  |                   | KIMBERLY   | GUDZUNE   | 22 S GRE   | EENE ST  | BALTIMORE MD   |
| 43                         | St<br>Regist   | ate               | 31. Date filed (Month, Day, Year)  | 32 Registrar's Signa                                | ature (  |  | ,  |
|                            | negisi   | rai .             | JUL 2 0 2000   | She Chan So   | - Manual -   |  |  |

|                     |   |                  | Pleas   | se Type or Print in<br>State of Maryla                                |                                    |  |  | _   | _                                     | ole.<br>Ac 22701                                       |  |  |
|---------------------|---|------------------|---|---|------------------------------------|--|--|---|---------------------------------------|--|--|--|
|                     |   |                  | For<br>State<br>Registrar   | Olato of Maryla   | -                                  | rtificate of l   |  |   | leg. No.                              | 10 22/01   |  |  |
|                     |   |                  | Decedent's Name (First, Middle  | , Last)   |                                    |  |  | 2. Date of Dea  | ıth                                   | 3. Time of Death                                       |  |  |
|                     | Physic<br>/Medi   |                  | Shirley   |   |                                    | Anderso  | on                                       | Month   |                                       | 96 4:50 P M  |  |  |
| 7                   | Exami   |                  | 4a. Facility Name (If not institution,  | give street and number)   |                                    |  | Location of Death                        |   | 4c. County of                         |  |  |  |
|                     |   |                  | Franklin Sa   | uare Hospita  | اہ                                 | Rosec  | lale                                     |   | Balt                                  | imore  |  |  |
|                     | Funeral   |                  |   | 6. Sex 7. Age (In yrs   | s. last birthday)                  | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs.<br>Hours Min.           | <ol> <li>8. Date of Birth</li> <li>9. Birthplace (State or Foreign</li> </ol> |                                       |  |  |  |
|                     | Director  |                  | 214-62-6937   | 1 <sup>1</sup> M <sup>2</sup> XF 55                                   | Yrs.                               |  |  | 01 30   | 51                                    | MD   |  |  |
|                     | and w   |                  | Usuel Residence of Decedent  10a. State 10b. County   | 10c. C  | City, Town or Lo                   | ocation  |  |   |                                       | 10d. Inside City Limits                                |  |  |
|                     | Maryl<br>1 ehc  | ō                | MD Bal  | timore  | м                                  | iddle Ri   | wor                                      |   |                                       | 1 ☐ Yes 21 No  |  |  |
|                     | 18 28a  | rect             | 10e. Street and Number  | CIMOLE  | FI                                 | 10f. Zip Code  | LVEL                                     |   | 10g. Citizen of W                     | hat Country?   |  |  |
|                     | 3a or   | Funeral Director | 9902 Tailspi  | n Iano Ant E  |                                    | 212  | 220                                      |   | U.S                                   | . Δ .  |  |  |
|                     | deeth   | Jera             | 11. Marital Status  | 12. Was Decedent Ever in Armed Forces?                                | U.S. 13.                           | Was Decedent of H  |  | pecify Yes or No-   |                                       | - American Indian,                                     |  |  |
| 9                   | or Its  | Ē                | 1 ☐ Never Married 2 💆 Marn  |   |                                    | 1 ☐ Yes 2 XNo  | Specify:                                 | riican, etc./   | Specify:                              | k, White, etc.   |  |  |
| 8                   | swithin 72 hours after deeth with the Maryland ilene.<br>r then "naturel", or iteme 23a or 28s-f ehow ite Madical Examiner must be notified at                      | d by             | 3 Widowed 4 Divorced  | Year or Dates:  |                                    |  |  |   |                                       | втяск  |  |  |
| 5                   | 72 h  | Completed        | 15. Decedent<br>(Specify only highes  | s Education<br>t grade completed)                                     | 16a. Dece<br>(Give                 | dent's Usual Occup<br>kind of work done of<br>DO NOT use retired | ation<br>during most of wor              | king  | 16b. Kind of Bus                      | siness/Industry<br>Hopkins                             |  |  |
| 7                   | within<br>lene.<br>then   | m                | Elementary/Secondary (0-12)   | College (1-4or 5+)  |                                    |  |  |   | Hospit                                | ~  |  |  |
| 5                   | Hygie<br>other  | ပိ               | 12th grade  17. Father's Name (First, Middle, I   | 2yrs  | Pnl                                | ebotomi  | 18. Mother's Nam                         | ne (First, Middle,  |                                       |  |  |  |
| an                  | ed ale  | o Be             | Robert Willi  | 3 m G   |                                    |  | Viola 3                                  | Iohnson   |                                       |  |  |  |
| 2                   | 2 should be<br>and Mente<br>ie marked<br>eumatic ev   | 10               | 19a. Informant's Name/Relationsh  |   | 19b. Maili                         | ng Address (Street   | and Number or Ru                         | ral Route Numbe   | r, City or Town, S                    | State, Zip Code)                                       |  |  |
| Maryland 21215-0036 | ~ ~ ~ ~   |                  | Jerri Drummon   | d_Daughter  |                                    | 2_Tails  |  |   |                                       | 21220<br>le River, Mo                                  |  |  |
|                     | s 1 and 2<br>1 Heelth<br>item 27<br>other tr  |                  | 20a. Method of Disposition  | 20b   | . Place of Dispo                   | osition (Name of matory or other place                           |  | Date  |                                       | City or Town, State                                    |  |  |
| 9                   | Page<br>ent o<br>nt: If<br>ry or  |                  | 1 □XBurial 2 □ Cremation<br>4 □ Donation 5 □ Other (St  | 3 □Removal from State   |                                    | morial E   |  | 21/06   | Randal                                | lstown, Md   |  |  |
| Baltimore,          | permit. Pages Department of Himportent: If ite eny injury or of 9000.   | 1                | 21. Signature of Funeral Service I  |   |                                    | 2. Name and Address  |  |   |                                       |  |  |  |
| ä                   | Depa<br>Impo<br>eny is  | -                | Nanowa  | make  | m 4                                | 300 Waba   | ash Ave                                  | Balti   | more,                                 | Md 21215   |  |  |
|                     |   |                  | 23a. Part 1. Enter the disease, or  | complications that caused the de                                      |                                    |  |  |   |                                       | Approximate<br>Interval Between                        |  |  |
|                     | Physician   |                  | Immediate Cause (Final disease or condition   | Tntracr   | anial                              | bloo   | ding                                     |   |                                       | Onset and Death  |  |  |
|                     | /Medical  |                  | resulting in death)   | Due to (or as a cons  |                                    |  | Cing                                     |   |                                       |  |  |  |
| н                   | Examiner  |                  | Sequentially list conditions  | hrombo  |                                    | penio  | 3  |   |                                       |  |  |  |
| _                   | p #   | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a cons  | equertse of):                      | 1  |  |   | ,                                     |  |  |  |
| /                   | and<br>trans  | Examiner         | Cause (Disease or Injury<br>that initiated events<br>resulting in death) Last                               | · Metastati   |                                    | ncer o   | of unk                                   | nown t  | rimaru                                | 1  |  |  |
| 60,                 | be executed<br>sicien and<br>burial-transit   | a E              | 1000tting in doziny 225t  | Due to (or as a cons  | equence or):                       |  |  | 1   | `                                     | )  |  |  |
| 687                 | physic<br>physic<br>s the b   |                  |   | d   |                                    |  |  |   | -                                     |  |  |  |
| 9 x                 | Physicien: The law requires thet the death certificate this certificete hes been signed by the attending phywart director, page 2 should be detached for use as the | Physician/Medic  | IF FEMALE:  | 23c. If yes, outcome of preg  | inancy                             |  |  |   | 22d Date                              | of delivery  |  |  |
| Box                 | atten<br>for u  | lan              | 23b. Was decedent pregnant in the past 12 months?   | 1 Live birth 2 ☐ Fe   | etal death 3                       | □Ectopic pregnancy □ Other (specify)                             | 1  |   | Mon                                   |  |  |  |
| P.0.                | the de<br>by the  | yslo             | 1 ☐ Yes 2 ₹ No<br>9 ☐ Unknown   | 9□ Unknown  | 1 000                              |  |  |   |                                       |  |  |  |
|                     | res thet the igned by be detact   |                  | Part II. Other significant condition  | ns contributing to death but not r                                    | esulting in the t                  | underlying cause giv   | en in Part I.                            | 23e. Did to   | bacco use contri                      | bute to the cause of death?                            |  |  |
| Records,            | quires<br>n sign  | d by             |   |   |                                    |  |  | 101   | es 2□No                               | 3 ☐ Probably 4 ☑ Unknown                               |  |  |
| Ö                   | w require<br>been sign  | Completed        |   |   |                                    |  |  | 24a. Was  | an 24b. W                             | Vere autopsy findings available                        |  |  |
| æ                   | he lav<br>e hes<br>age 2  | Ē                |   |   |                                    |  |  |   | med?/ de                              | rior to completion of cause of<br>eath?<br>□ Yes 2□ No |  |  |
| tal                 | en: Tifice  | Be               | 25. Was case referred to medical  |   |                                    |  | 26. Place of Dea                         | 1 ☐ Yes   | -                                     |  |  |  |
| of Vital            | ding Physiclen: The h.<br>h.<br>After this certificete he funeral director, page  | To B             | examiner? 1 Yes 2 No  | Hospital: 1 Thepatient 2  | ☐ ER/Outpatie                      | nt 3 DOA Oth   | 05                                       | - V   | lence 6 Othe                          | ır (Specify)   |  |  |
|                     | g Ph<br>ter th  |                  | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year)                              | 28b. Time o                        | of 28c. Injur<br>Wor   | y at                                     | 28d. Describe h   | ow injury occurre                     | be   |  |  |
| jo                  | ath.<br>ar: Af  | atlc             | 1√2Natural 5 Pendin<br>2 Accident investion   | pation  | , ,,,,,                            |  | Yes 2 □ No                               |   |                                       |  |  |  |
| Division            | r Atte<br>er de<br>recto  | Certification:   | 3 ☐ Suicide 6 ☐ Could in determine  |   | home, farm, si                     | treet, factory, office   |  | 28t. Location (5<br>City or Tox   |                                       | er or Rural Route Number,                              |  |  |
|                     | ital o  | Cer              |   |   |                                    |  |  |   |                                       |  |  |  |
|                     | To the Hospital or Attending within 24 hours atter death. To the Funeral Director: After completely filled in by the fune   | Medical          | (Check only 2 Medical   | g Physician: To the best of my k<br>Examiner: On the basis of exami   | nowledge, dea<br>ination and/or in | th occurred at the tirn<br>exestigation, in my o                 | ne, date and place<br>pinion, death occu | , and due to the or<br>rred at the time,                                      | cause(s) and mar<br>date and place, a | ner as stated.<br>nd due to the cause(s)               |  |  |
|                     | the the the the the the the the the the   | Med              | one) 29b. Signature and title of certifie   | and manner stated.  |                                    | 29c. Licens  | e number                                 |   | 29d. Date signed                      | (Month, Day, Year)                                     |  |  |
|                     | F . F . S   | -                | 250. Signature and the street   | am his  |                                    | 130  |  |   | 7/15/                                 |  |  |  |
|                     |   |                  | 20 Name and address of second   | who completed cause of death (II                                      | tem 22a) /T                        |  | , ,                                      |   |                                       | ~  |  |  |
|                     | 6   |                  | Dr. Kirmani   | who completed cause of death (II                                      | P. W. Is Lin                       | Samare   | Drivo Pro                                | Itimore   | MD 2                                  | 1237   |  |  |
|                     | S   | ate              | 31. Date filed (Month, Day, Year)   | who completed cause of death (II)  hmed, 9000 Fr  32. Registrar's Sig | gnature                            | - Jane   | OTIVE, NO                                | . [ 1] 1 1 4 1 0  | 1.                                    |  |  |  |
|                     | Regis   |                  | 1111 2  | 0 2006  | 1 1                                | Courte   |  |   |                                       |  |  |  |
|                     |   | _                |   |   |                                    |  |  |   |                                       |  |  |  |

|  |  | For   | • •  | <b>Black Indelible Ink.</b><br>d / Department of He  | ealth and Men   | -  |  | 22702  |
|--|--|---|--|--|---|--|--|--|
|  |  | = State<br>Registrar  |  | Certificate of D   | Death   | Reg. N   | 0.   |  |
| 384  |  | Decedent's Name (First, Middle, Last)   |  |  |   | Date of Death<br>Month D   | ay Year,   | 3. Time of Death   |
| Physic<br>/Medi  | A  | Henry E. Addis  | son  |  |   | MLY 16   | 2006   | 12:23 PM   |
| Exami  |  | 4a. Facility Name (If not institution, give s<br>SINAL Hospita  | Δ.   | 4b. City, Town, or TIMERE BALTI  |   | 0 4  | c. County of Death<br>n/a  |  |
| Funeral<br>Director  |  | 5. Social Security Number 6. Sex  |  |  | Hours Min. (  | Date of Birth<br>Month, Day, Yea<br>/4/195   |  | place (State or Foreign<br>otry)<br>cyland   |
| Q .  |  | Usual Residence of Decedent   |  |  |   | 7 1 1 7 3  |  | 10d. Inside City Limits  |
| Marylar<br>f show  | tor  | MD Baltimo:   |  | y, Town or Location indsor Mill  |   |  |  | 1 ☐ Yes 2 ☐ No   |
| with the   | Direc  | 10e. Street and Number 38 Triple Crow   | n Court  | 10f. Zip Code  | 21244   | 10g. C   | Citizen of What Cour<br>USA  | ntry?  |
| be filed within 72 hours after death with the Maryland tal Hygiene. Indi Hygiene. Indicate then "natural", or Iteme 23a or 28a-f show event, the Madical Examinat must be confilled at   | by Funeral Director  |   | 12. Was Decedent Ever in U.<br>Armed Forces?<br>1 ☐ Yes 2 No<br>If Yes, Give X   | S. 13. Was Decedent of His If Yes, specify Cubar   | spanic Origin? (Specify<br>, Mexican, Puerto Rica<br>Specify:   | Yes or No-<br>n, etc.)   | Specify:   | etc.<br>cican-   |
| tural'   |  | 15. Decedent's Educ   | Year or Dates:   | 16a. Decedent's Usual Occupa   | tion  | 16b  | Amer Kind of Business/In   | 1can<br>dustry   |
| within 72<br>ane.<br>then national   | Completed  | (Specify only highest grade Elementary/Secondary (0-12)   | College (1-4or 5+)   | (Give kind of work done dife. DO NOT use retired)  Environmenta  | uring most of working   | Ti   | de Wate  | •  |
| e filed v<br>il Hygie<br>other i   | Be Co  | 17. Father's Name (First, Middle, Last)   | 11   |  | 18. Mother's Name (Fig.   | st, Middle, Maide  |  |  |
| should by and Menta to marked umatic en  | ToE  | Henry H. Addis  | on   |  | Thelma  |  |  |  |
| re, Indryld s 1 and 2 should f Health and Men item 27 is marke other traumatic   |  | 19a. Informant's Name/Relationship (Type  |  | 19b. Mailing Address (Street a 38 Triple C1  |   |  |  |  |
| E, R<br>1 and<br>1 and<br>1 ealth<br>1 m 27<br>1 her t   |  | Thelma Addison/ 20a. Method of Disposition  |  | The state of the s |   |  | Location - City or To  |  |
| 0 8°= 9  |  | 1 Burial 2 □ Cremation 3 □ R  | emoval from State  | Place of Disposition (Name of emetery, crematory or other place  | 7/21/0  |  | ndallsto   |  |
|  |  | 4 □ Donation 5 □ Other (Specify)  21. Signal 4 of Funeral Strice Licepse  |  | g Mem. Park 22. Name and Addres  |   |  |  | Balto. Co  |
| Depariment impo  |  | Montherally   | Mark   | 9200 Libe:   |   |  |  | MD 21133   |
|  |  | 232 Part 1. Enter the disease, or complete shock, or heart failure. List only on  | eations that caused the death  |  |   |  |  | Approximate  |
| Physician  |  |   |  |  |   |  |  | Interval Between   |
| 18.0 - ali a - 1   |  | Immediate Cause (Final disease or condition resulting in death)   | massine  | cerebrale  | 2 4   |  | ion  | Onset and Death  2 days  |
| /Medical<br>Examiner   |  | Immediate Cause (Final disease or condition resulting in death)   | Due to (or as a conseq   | cerebrale  |   |  | ion  |  |
| Examiner   | ler  | disease or condition resulting in death)  | massine  | cerebral e<br>uence of:<br>e & CVA   |   |  | ion  |  |
| Examiner   | amlner   | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | Due to (or as a consequence)   | cerebral e<br>uence of:<br>e & CVA   |   |  | ron  |  |
| examiner an and irial-transit  | al Examiner  | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | Due to (or as a consequence to (or as a consequence to consequence)  Due to (or as a consequence to consequence | cerebral e uence of): e C C V A uence of):   |   |  | ron  |  |
| examiner an and irial-transit  |  | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | Due to (or as a consequence to (or as a consequence to consequence)  Due to (or as a consequence to consequence | cerebral e uence of): e C C V A uence of):   |   |  | ion  |  |
| e attending physician and dor use as the burial-transit  |  | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No   | Due to (or as a consequence to (or as a consequence to consequence)  Due to (or as a consequence to consequence | uence of):  uence of):  uence of):  uence of):   |   |  | 23d. Date of deliv   | Onset and Death 2 class  |
| e attending physician and dor use as the burial-transit  | Physician/Medical  | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  | Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)   | uence of):  uence of):  uence of):  uence of):  uence of):  ancy I death   | dema + 1  | Verniat  | 23d. Date of deliv   | Onset and Death  2 days  3 crony-  ery  Day Year   |
| e attending physician and dor use as the burial-transit  | by Physician/Medical                                       | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)   | uence of):  uence of):  uence of):  uence of):  uence of):  ancy I death   | dema + 1  | 23e. Did tobacci   | 23d. Date of deliv<br>Month  | ery Day Year   |
| e law requires that the death certificate be executed that the death certificate be executed that been signed by the attending physician and the 2 should be detached for use as the burial-transit to   | by Physician/Medical                                       | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)   | uence of):  uence of):  uence of):  uence of):  uence of):  ancy I death   | dema + 1  | 23e. Did tobacc<br>1  Yes<br>24a. Was an<br>autopsy<br>performed;  | 23d. Date of delive Month  Do use contribute to to to 2 \( \times \) No \( 3 \) Produce Prior to expect death?   | onset and Death  2 class  Class  Pery Day Year  The cause of death?  bably 4 DUnknown  Dopsy findings available ompletion of cause of                  |
| The law requires that the death certificate be executed the law requires that the death certificate be executed that has been signed by the attending physician and page 2 should be detached for use as the burial-transit  | e Completed by Physician/Medical                           | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)   | uence of):  uence of):  uence of):  uence of):  ancy I death 3   Ectopic pregnancy leath 5   Other (specify)   | dema + 1  | 23e. Did tobacc<br>1  Yes<br>24a. Was an<br>autopsy<br>performed;<br>1 Yes 2 1   | 23d. Date of delive Month  Do use contribute to to to 2 \( \times \) No \( 3 \) Produce Prior to expect death?   | ery Day Year  the cause of death? bably 4 Dunknown   |
| vital Records, P.O. Box 68/60, A. sicien: The law requires that the death certificate be executed to certificate has been signed by the attending physician and irrector, page 2 should be detached for use as the burial-transit  | o Be Completed by Physician/Medical                        | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions con | Due to (or as a consequence).  Due to (or as a consequence).  Due to (or as a consequence).  Due to (or as a consequence).  Constituting to death but not reserved.  | uence of):  uence of):  uence of):  uence of):  ancy I death 3   Ectopic pregnancy leath 5   Other (specify)   | on in Part I.  26. Place of Death (C  | 23e. Did tobacco   | 23d. Date of delive Month  Do use contribute to to to the contribute to to the contribute to the contr | ery Day Year  the cause of death? bably 4 Dunknown  psy findings available ompletion of cause of 2 No  |
| r Vital Records, P.O. Box 68/60,  ysician: The law requires that the death certificate be executed to secretificate has been signed by the attending physician and director. page 2 should be detached for use as the burial-transit   | To Be Completed by Physician/Medical                       | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence).  Due to (or as a consequence).  Due to (or as a consequence).  Due to (or as a consequence).  Consequence of pregnant and pregnant at time of dependence of the pregnant at time of dependence o | uence of):  uence  | on in Part I.  26. Place of Death (Car. 4   Nursing Home  | 23e. Did tobacco   | 23d. Date of delive Month  Do use contribute to to to to to to to to to to to to to  | ery Day Year  the cause of death? bably 4 Dunknown  psy findings available ompletion of cause of 2 No  |
| utending Physician: The law requires that the death certificate be executed death.  The law requires that the death certificate be executed death.  Start: After this certificate has been signed by the attending physician and the tineral director, page 2 should be detached for use as the burial-transit                     | To Be Completed by Physician/Medical                       | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence of the consequence of t | uence of):  uence  | en in Part I.  26. Place of Death (Certification of the center of the c | 23e. Did tobacce 1 Yes 24a. Was an autopsy performed; 1 Yes 2 Theck only one) 5 Residence Describe how in  | 23d. Date of delive Month  Do use contribute to to the contribute  | ery Day Year  the cause of death? bably 4 Dunknown  posy findings available empletion of cause of 2 No   |
| utending Physician: The law requires that the death certificate be executed death.  The law requires that the death certificate be executed death.  Start: After this certificate has been signed by the attending physician and the tineral director, page 2 should be detached for use as the burial-transit                     | Certification: To Be Completed by Physician/Medical        | disease or condition resulting in death)  Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence of the consequence of t | uence of):  uence  | an in Part I.  26. Place of Death (Car. 4   Nursing Home at (Car. 28d. 28d. 28d. 28d. 28d. 28d. 28d. 28d  | 23e. Did tobacci 1 Yes  24a. Was an autopsy performed; 1 Yes 2 1 heck only one)  5 Residence Describe how in   | 23d. Date of delive Month  Do use contribute to to the second of the sec | ery Day Year  the cause of death? bably 4 DUnknown  posy findings available empletion of cause of 2 No  fy)  |
| OT VI(al Hecords, P.O. Box 68/60,  Physician: The law requires that the death certificate be executed to this certificate has been signed by the attending physician and main director, page 2 should be detached for use as the burial-transit  | To Be Completed by Physician/Medical                       | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence of the consequence of t | uence of):  uence  | en in Part I.  26. Place of Death (Certification of the Part I.)  27. 4 \( \text{Nursing Home} \)  28d. Yes 2 \( \text{No} \)  28f. The date and place, and pinion, death occurred a second of the Part I.  | 23e. Did tobacce 1 Yes 24a. Was an autopsy performed; 1 Yes 2 1 teck only one) 5 Residence Describe how in Location (Street City or Town, Statute time, date at the time, date | 23d. Date of delive Month  Do use contribute to the second of the second | ery Day Year  the cause of death? bably 4 Dunknown  posy findings available empletion of cause of 2 No  fy)  al Route Number,  stated. to the cause(s) |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | edical Certification: To Be Completed by Physician/Medical | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence of the consequence of t | uence of):  uence  | en in Part I.  26. Place of Death (Certification of the Part I.)  27. 4 \( \text{Nursing Home} \)  28d. Yes 2 \( \text{No} \)  28f. The date and place, and pinion, death occurred a second of the Part I.  | 23e. Did tobacce 1 Yes 24a. Was an autopsy performed; 1 Yes 2 1 teck only one) 5 Residence Describe how in Location (Street City or Town, Statute time, date at the time, date | 23d. Date of delive Month  Do use contribute to the second of the second | ery Day Year  the cause of death? bably 4 Dunknown  posy findings available empletion of cause of 2 No  fy)  al Route Number,  stated. to the cause(s) |
| utending Physician: The law requires that the death certificate be executed death.  The law requires that the death certificate be executed death.  Start: After this certificate has been signed by the attending physician and the tineral director, page 2 should be detached for use as the burial-transit                     | edical Certification: To Be Completed by Physician/Medical | disease or condition resulting in death)  Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence of the consequence of t | uence of):  uence  | en in Part I.  26. Place of Death (Certification of the Part I.)  27. 4 \( \text{Nursing Home} \)  28d. Yes 2 \( \text{No} \)  28f. The date and place, and pinion, death occurred a second of the Part I.  | 23e. Did tobacce 1 Yes 24a. Was an autopsy performed; 1 Yes 2 1 teck only one) 5 Residence Describe how in Location (Street City or Town, Statute time, date at the time, date | 23d. Date of delive Month  Do use contribute to the second of the second | ery Day Year  the cause of death? bably 4 Dunknown  posy findings available empletion of cause of 2 No  fy)  al Route Number,  stated. to the cause(s) |

DHMH 17 Rev 1/2001

State Registrar

JUL 2 0 2006

|  |                  | 1 - For Amend #11, per  | State of Marylan<br>Inf, G863,1/24/07   | d / Departme<br><sup>TT</sup> <i>Certifica</i>        | nt of Health and te of Death                                     | Mental Hygiei                                       | ne2 () () ()                              | 22703  |
|--|------------------|---|---|---|--|---|---|--|
|  |                  | Decedent's Name (First, Middle, La                                      | 151)  |   |  | 2. Date of Death                                    | Day Yeer                                  | 3. Time of Death                                   |
| Physic<br>/Medi  |                  | DONNEll P.  | Buchana   | N   |  | July 1  | 4 2006                                    |  |
| Exami  | 6.               | 4a. Fecility Name (If not institution, gire                             | ve street and number)   | 4b. Cit   | y, Town, or Location of Deal                                     | h *   | 4c. County of Death                       | 10/2   |
| Funeral  |                  | 5. Social Security Number 6.  | Sex 7. Age (In yrs.   |   | er 1 Year If Under 24 Hrs<br>S Days Hours Min                    |   | 9. Birth                                  | plece (Stete or Foreign                            |
|  |                  | 217-82-9111   | 10M 20F 43  | Yrs. Month  | s Days Hours Min   | July 2;   | 963                                       | Md   |
| Director  The Maryland  Table 1 show   |                  | Usuel Residence of Decedent  10a. State 10b. County                     | 10c. Cit  | y, Town or Location                                   |  |   |   | 10d. Inside City Limits                            |
| the Marylan  | to               | Ma N/   | A   | Baltimo   | re   |   |   | 1 Yes 2 No   |
| or 288-1   | Olrec            | 10e. Street and Number  | <i>a</i>  |   | Zip Code   | 10g.  | Citizen of What Cou                       | intry?   |
| 036 Us after death with the Maryland us after death with the Maryland sit, or items 23a or 28a-1 show Examiner must be notified at   | Funeral Director | 3914 Southe   | 12. Was Decedent Ever in U  | S 13 Was Dec  | 21200  | Specify Yes or No-                                  | 14. Race - Amer                           | ican Indian,                                       |
|  | Fune             | 11. Marital Status  Never Married 2 Married                             | Armed Forces?   |   | bedent of Hispanic Origin? (Specify Cuban, Mexican, Puel         | to Rican, etc.)                                     | Black, White                              |  |
|  | b                | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:  | 1 L Yes   | 2No Specify:   |   | Specify: B                                | ack  |
| DONNEL Ind 21215-0036 be fited within 72 hours atter ital tygiene. d other than "naturat", or ite event, the Wedical Examina   | Completed        | 15. Decedent's E<br>(Specify only highest gi                            | Education<br>rade completed)  | 16a. Decedent's Us<br>(Give kind of s<br>life. DO NOT | work done during most of wo                                      |   | . Kind of Business/li                     | ndustry  |
| 2121<br>2121<br>ad within<br>rgiene.<br>er than  | фщо              | Elementary/Secondary (0-12)   | College (1-4or 5+)  | Custod  |  | De  | pt. of Po                                 | ablic Work   |
| it Hygin other   | Be C             | 17. Father's Name (First, Middle, Las                                   | t)  | 0 4 3 4   |  | me (First, Middle, Maid                             | den Sumame)                               |  |
| faryland 212:<br>2 should be filed within<br>and Mental Hygiene.<br>Is marked other than<br>raumatic event, tuest  | To E             | Vernon Buch   | anan  |   | Sylvi  |   |   |  |
| re, Maryland<br>s 1 and 2 should be file<br>Health and Mental Hy<br>tiem 27 is marked oth  |                  | 19a. Informant's Name/Relationship                                      | (Type, Print) Father  | 0.0   | ess (Street and Number or A                                      | 0   | altimore                                  | 111 00000  |
| 2 a a a  |                  | VerNON Buch 20a Method of Disposition                                   | 20b. F  | Place of Disposition (A                               |  |   | Location - City or T                      | 4  |
| ages ent of nt: If it  |                  | 1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec                   | Hemoval from State  | ng Mem P  |  | 21/06 1   | Joodlawn                                  | Md   |
| Baltimore, permit. Pages 1 at Department of Hee Important: if item any injury or othe  |                  | 21. Signature of Funeral Service Lice                                   |   |   | and Address of Famility  | hatman -  |   | Funeral Hei  |
| <b>0</b> 88558   | 16. 7            | 23a. Part1. Enter ye disease, or co                                     | 4   | 5940  | Reistersto   | wn hd   | Baltimo                                   |  |
|  |                  | shock, or pearl failure. List on  | y one cause on each line.   |   |  | ic or respiratory arrest,                           |   | Approximate<br>Interval Between<br>Onset and Death |
| Physician<br>/Medical  |                  | Immediate Cause (Final disease or condition resulting in death)         | a. TERMINMO<br>Due to (or as a consec   |   | EMENTIA  |   |   | two month  |
| Examiner   |                  |   |   | (201100 01).  |  |   |   |  |
| P 1./=   | ner              | if any, leading to immediate cause. Enter Underlying                    | b. Due to (or as a consec   | juence oi):   |  |   |   |  |
| 3760,<br>ate be executed<br>hysician and K   | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last | c<br>Due to (or as a consec   | quence of):   |  |   |   |  |
| 760,<br>te be ex<br>ysician  | calE             |   | . 4   | ,   |  |   |   |  |
| 687<br>tificate<br>ng phys<br>as the   |                  |   |   |   |  |   |   |  |
| Box 68 eath certifica attending ph   | Physician/Med    | IF FEMALE:<br>23b. Was decedent pregnant                                | 23c. If yes, outcome of pregn<br>1 Live birth 2 Feta                                    |   | pregnancy  |   | 23d. Date of delin                        | very<br>Day Year                                   |
| O. B<br>ne dear<br>the att   | sicia            | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                       | 4 ☐ Pregnant at time of o   | death 5 ☐ Other                                       | (specify)  |   | I I I I I I I I I I I I I I I I I I I     |  |
| P.O. Be that the death ed by the atterdet for the detached for the atterdet for the atterde | Ph)              | Part II. Other significant conditions                                   | contributing to death but not res   | sulting in the underlyin                              | g cause given in Part I.   | 23e. Did tobac                                      | co use contribute to                      | the cause of death?                                |
| cords, F<br>w requires tha<br>been signed is   | d by             |   |   |   |  | 1 🗆 Yes   | 2 □ No 3 □ Pro                            | obably 4 Turknown                                  |
| aw rec   | piete            |   |   |   |  | 24a. Was an autopsy                                 | 24b. Were au                              | topsy findings available ompletion of cause of     |
| I Rec  | Completed        |   |   |   |  | performed<br>1 ☐ Yes 2 ☐                            | d?   death?                               |  |
| Division of Vital Records, to attending Physician: The law requires tatler death.  Director: After this certificate has been signe in by the funeral director, page 2 should be  | Be               | 25. Was case referred to medical examiner?                              | Hospital:   |   | Other  | eath (Check only one)                               |   |  |
| on of Vita<br>ding Physician:<br>h.<br>After this certific<br>funeral director,  | <u>۲</u>         | 1 Yes 2 No 27. Manger of Death  | 1   Inpatient 2   | ER/Outpatient 3 28b. Time of                          | DOA 4 Mursing 28c. Injury at Work?                               | Home 5 Residence 28d. Describe how                  |   | ufy)   |
| on on ding F   | Certification:   | 1 Natural 5 ☐ Pending 2 ☐ Accident investigat                           | 28a. Date of Injury<br>(Month, Day Year)  | Injury<br>M   | Work?<br>1 ☐ Yes 2 ☐ No  |   |   |  |
| Division of attending after death.   | tifica           | 3 Suicide 6 Could not determine   |   | nome, farm, street, fac                               | tory, office   | 28f. Location (Stree<br>City or Town, S             | et and Number or Ru<br>State)             | ral Route Number,                                  |
| Di<br>ital or<br>irs after<br>ral Dii  |                  |   |   |   |  | and disc to the co                                  |   | alatad   |
| Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as it  | Medicai          | 29a. Certifier 1 Certifying (Check only one) 2 Medicel Ex               | Physician: To the best of my kn<br>eminer: On the basis of examin<br>and manner stated. | owledge, death occurr<br>ation and/or investigat      | red at the time, date and pla-<br>tion, in my opinion, death oc- | ce, and due to the caus<br>curred at the time, date | se(s) and manner as<br>and place, and due | stated.<br>to the cause(s)                         |
| o the ather o the control of the con | Med              | 29b. Signature and title of certifier                                   | And married stated.   |   | 29c. License number  |   | Date signed (Month                        |  |
| F ≥ F 8  |                  | > Nelvah )  | Liene   |   | 445931   |   | July 18th                                 | 2006   |
| <u>ن</u>   |                  | 30. Name and address of person w  | o completed cause of death (Ite   | m 23a) (Type, Print)                                  | 445931<br>ughb Aveni   | 10 Rollin   | mone MA                                   | 21908  |
|  | 101              | 31. Date filed (Month, Day, Year)                                       | 32. Registrar's Sign  | ature & M   | your were  | ic become   | 1W/Colve                                  |  |
| Regis  | tate             |   | 06 Bearing &  | 1 19968   | ,  |   |   |  |

|            |  |                | 1 10430   |   |                             | indicink. Liisuic A  | -  | _                         |   |
|------------|--|----------------|---|---|-----------------------------|--|--|---------------------------|---|
|            |  |                | For   | State of Maryla   |                             | ment of Health and I   | Mental Hygien                                | e 2005                    | 22701                                       |
|            |  |                | 1 - State<br>Registrar  |   | Certif                      | icate of Death   | Reg. N                                       | lo.                       | C C 1 O -1                                  |
|            |  |                | 1. Decedent's Name (First, Middle, La   | st)   | /                           | 7 ,  | 2. Date of Death                             |                           | 3. Time of Death                            |
|            | Physic   |                | Milhiam   |   |                             | MAKS   | Month D                                      | Year                      | 13:50 M                                     |
|            | /Medi<br>Examir  |                | 4a. Facility Name (If not institution, give   | re street and number)                                   | 41                          | o. City, Town, or leocation of Deatl   | tour y                                       | c. County, of Death       | 10104                                       |
|            | CXamil   | ier            | 71 1.6 11   | Melica Ilana  | 1/1/                        | 12-1-1:  | 100.10                                       | 11/1                      |   |
|            |  |                | The Johns Ho  | MICINIS HOSP  | Tal !                       | Under 1 Year If Under 24 Hrs.  | Orty   | 11/4                      |   |
|            | Funeral  |                | Dia - Haci  | *C7   |                             | onths Days Hours Min.  | (Month, Day, Yea                             | r) Cou                    | place (State or Foreign ntry)               |
|            | Director   |                | K12-20-1/61   | 85  | 115.                        |  | NOV 23 19                                    | 120                       | Georgia                                     |
|            | p ,  |                | Usual Residence of Decedent  10a. State 10b. County   | 1100.0  | She Tanana I ami            |  |  |                           | ,   |
|            | aho,   | _              | 111   |   | city, Town or Locati        |  |  |                           | 10d. Inside City Limits                     |
|            | Ma<br>P-1-   | ot o           | Md Salt   | imore   | Tows                        |  |  |                           | 1 Yes 2 No                                  |
|            | F 28   | Director       | 10e. Street and Number  |   |                             | Of. Zip Code   | 10g. C                                       | Citizen of What Cou       | ntry?                                       |
|            | 38 o   | 0              | 281 B Henda   | ichson Lai  | N2                          | 21286  |  | USA                       |   |
|            | within 72 hours after deeth with the Maryland<br>ane.<br>then "naturaf, or Itams 23s or 28s-f show<br>he Medical Evarrings that the tridified at   | Funeral        | 11. Marital Status  | 12. Was Decedent Ever in I                              |                             |  | pacify Yas or No-                            | 14. Race - Ameri          | can Indian                                  |
|            | le le le le le le le le le le le le le l   | 5              | 1 ☐ Never Married 2 ☐ Married   | Armed Forces? 1 ☐ Yes 2 No                              | If Ye                       | Decedent of Hispanic Origin? (S<br>is, specify Cuban, Mexican, Puert         | o Rican, etc.)                               | Black, White,             |   |
| 36         | rs af  | by             | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates:                          | 10                          | Yes 2 No Specify:  |  | Specify: Ri               | 2016  |
| 21215-0036 | hou  | B              |   |   | 1 10: 5                     |  |  | 91                        | acr   |
| 5          | 72<br>nei  | Completed      | 15. Decedent's E<br>(Specify only highest gr  | ducation<br>ade completed)                              | 16a. Decedent               | 's Usual Occupation<br>d of work done during most of wor<br>NOT use retired) | rking 16b.                                   | Kind of Business/In       | ndustry                                     |
| 7          | ig 9 9 9   | ם              | Elementary/Secondary (0-12)   | College (1-4or 5+)                                      |                             |  |  | 11.                       |   |
| 7          | filed with<br>Hygiene.<br>Wher the   | Ö              |   |   | 11500                       | CK Driver  |  | altimora                  | - County                                    |
| b          | be file<br>tal Hy<br>d oth   | Be             | 17. Father's Name (First, Middle, Lasi  | )   |                             | 18. Mother's Nan   | ne (First, Middle, Maide                     | n Sumame)                 |   |
| 0          | Mental<br>Mental<br>arked o  | 5              | Lucius Bon  | MS  |                             | i)ane  | Edwards                                      | 4                         |   |
| 2          | and N<br>fs mai  | -              | 19a. Informant's Name/Relationship  | Type, Print)  | 19b. Mailing A              | ddress (Street and Number or Ru  | ral Route Number, City                       | or Town State Zin         | Code)                                       |
| Maryland   | nd 2<br>pith ai<br>27 fs<br>r trau   |                | Janelle Whi   | 10 Nize   | 2911                        |  | , ,  |                           |   |
| _          | ges 1 and 2 should be filed within 72 hours after deeth with the Marylar at of Heelth and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23s or 28s-f show or other traumatic event, the Medical Examiner must be inclined at | 100            | 20a. Method of Disposition  | 10 /1.  | Place of Disposition        | B Hendricks  |  |                           |   |
| Baltimore, | Pages<br>nent of H<br>int: if Itu  |                | 1 Burial 2 Cremation 3  | Removal from State                                      | cemetery, cremato           | ry or other place)   | 200.   | Location - City or To     | own, State                                  |
| <u>=</u>   | Fr in a  |                | 4 □Donation 5 □Other (Speci   | S) Ge   | zen licu                    | Ja Canter 7/2  | 24/06 3                                      | allimore                  | Md  |
| Ħ          | permit. Departr Import   |                | 21. Signature of Funeral Service Lice   | nsee  | 22. N                       | ame and Address of Famility C  | hatman-t                                     | farris Fur                | veral Home                                  |
| m          | Dep<br>Imp   |                | Esa Stark   |   | 534                         | 5 Parstock   | 1818.  | timore M                  | 121215                                      |
|            |  |                | 23a. Port1. Enter the disease, or commonly thock, or heart failure. List only   | plications that caused the dea                          | ath. Do not enter the       | te mode of dving such as cardiac   |  | 4114/26 2 101             | Approximate                                 |
| - 18       |  |                |   | one cause on each line.                                 | C 4                         | · []   | or rospiratory arrost,                       |                           | Interval Between<br>Onset and Death         |
|            | Physician  |                | Immediate Cause (Final disease or condition   | a. Sul more   | any C                       | dema   |  | i i                       | 3 Hours                                     |
|            | /Medical   |                | resulting in death)   | Due to (or as a conse                                   | quence o):                  |  |  | 1                         |   |
|            | Examiner   |                | Garage Market Banks and Anti-   | b. Hyper  | tensi                       | ON   |  |                           | 3 years                                     |
|            |  | Jer            | if any, leading to immediate  | Due to (ar as a conse                                   | quence of):                 |  |  |                           | 1   |
|            | B A E  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |   |                             |  |  |                           |   |
|            | al-tra   | xa             | resulting in death) Last  | Due to (or as a conse                                   | quence of):                 |  |  |                           |   |
| 760        | ysicien and  | calE           |   |   |                             |  |  |                           |   |
| 87         | 2 2 9  |                | •   | d   |                             |  |  |                           |   |
| <b>68</b>  | The law requires that the death certificat sie has been signed by the attending phycegge 2 should be detached for use as the   | Physician/Med  | IF FEMALE:  |   |                             |  |  |                           |   |
| ŏ          | thoe   | an/            | 23b. Was decedent pregnant  | 23c. If yes, outcome of pregr<br>1 ☐ Live birth 2 ☐ Fet |                             | opic pregnancy   |  | 23d. Date of delive       | ery   |
| œ.         | dea<br>e att   | 0              | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4 ☐ Pregnant at time of                                 |                             | ner (specify)  |  | Month                     | Day Year                                    |
| P.0        | that the de<br>ned by the a<br>detached  | hys            | 9 □ Unknown /   | 9□ Unknown  |                             |  |  |                           |   |
|            | the det  |                | Part II. Other significant conditions   | contributing to death but not re                        | sulting in the under        | lying cause given in Part I.   | 23e. Did tobacco                             | use contribute to the     | he cause of death?                          |
| ds         | signed I   | d by           |   |   |                             |  | 1 ☐ Yes                                      | 2□No 3□Prob               | pably 4 Ninknown                            |
| Records,   | w requir<br>been si<br>should  | Completed      |   |   |                             |  |  | 2010 001101               | Jabiy 4 John Mill                           |
| ec         | e law<br>hes b   | ם              |   |   |                             |  | 24a. Was an autopsy                          | 24b. Were auto            | psy findings available mpletion of cause of |
| Œ          | The I  | 5              |   |   |                             |  | performed?                                   |                           | ampietion of cause of                       |
| Vital      |  | Be C           | 25. Was case referred to medical  |   |                             | 26 Place of Dog  | th (Check only one)                          | lo 1 □ Yes                | 2LI NO                                      |
| 5          | Physician:<br>this certificand director,   |                | examiner?<br>1 N Yes 2 □ No   | Hospital: 1 ☐ Inpatient 2)                              | ER/Outpatient :             | Other  |  | - 0-                      |   |
| ō          | Phy<br>raid<br>raid  | - To           | 27. Manner of Death   | 28a. Date of Injury                                     | 28b. Time of                | A Nursing H  | ome 5 Residence<br>28d. Describe how inj     |                           | (Y)   |
| Division   | Attending Is death.  ector: After by the tuner   | Certification; | 1 Natural 5 ☐ Pending   | (Month, Day Year)                                       | Injury                      | 28c. Injury at<br>Work?  | 200. Describe now inj                        | ary occurred              |   |
| . <u>S</u> | teat<br>for:<br>the  | cal            | 2 Accident investigation 3 Suicide 6 Could not be   |   | 1                           | M 1 Yes 2 No   |  |                           |   |
| .≥         | or Attaneller deatl  | E              | 4 Homicide determined   | 28e. Place of tnjury - At I<br>building, etc. (Spec     | nome, farm, street,<br>ify) | factory, office  | 28f. Location (Street a<br>City or Town, Sta | ind Number or Rura<br>te) | al Route Number,                            |
|            | s ef   | Ce             |   |   |                             |  |  |                           |   |
|            | To the Hospital or Attandi<br>within 24 hours efter death.<br>To the Funeral Director: A<br>completely filled in by the to   |                | 29a. Certifier Certifying Pl  | nysician: To the best of my kn                          | owledge, death oc           | curred at the time, date and place   | , and due to the cause(                      | s) and manner as s        | tated.                                      |
|            | T 47 0   | Medical        | (Check only a Medical Example one)  | niner: On the basis of examin<br>and manner stated.     | ation and/or invest         | gation, in my opinion, death occu  | rred at the time, date at                    | nd place, and due to      | the cause(s)                                |
| _          | To the within 2  | Me             | 29b. Signature and title of certifier   |   |                             | 29c. License number  | 29d. D                                       | ate signed (Month,        | Day, Year)                                  |
|            | r s r ö  |                | 101/h   | 4 ~   |                             | D00354   | 1.0  | 1.1                       | 11 5 00 0                                   |
|            | _  |                | , and   | 1   |                             |  | _  | 1414                      | 14,2002                                     |
|            | 2  |                | 30. Name and address of person who  |   | 23a) (Type, Prin            | " TOWNS !  | Sprkins                                      | en                        | BATIMORE.                                   |
| _          |  |                | MORACC  | LIANG   | MD                          | 600 N  | OVTH in                                      | OLFE                      | MD 2126                                     |
|            | Sta  |                | 31. Date filed (Month, Day, Year)   | 32 Registrar's Sign                                     | ature                       |  |  |                           |   |
| 10.00      | Regist   | ar             | 1111 9 0 20   | 110 / 254   | 5% 5200 A                   | 7. /   |  |                           |   |

| 06-04985   |                |  |                          |                                     |               |                |                   | idelible ink                |                                |                        |                |  |
|--|----------------|--|--------------------------|-------------------------------------|---------------|----------------|-------------------|-----------------------------|--------------------------------|------------------------|----------------|--|
| Rafik Bagirov  |                |  | State of                 | Maryland                            |               |                |                   | and Mental                  | Hygiene                        |                        | 000            | F ODTO   |
|  |                | 1- For State<br>Registrar                                  |                          |                                     | Cert          | ificate c      | of Death          |                             | Re                             | g. No.                 | 200            | 0 22/0   |
| Physicia   |                | 1. Decedent's Name (First,                                 | Middle,Last)             |                                     |               |                |                   |                             | Date of Deat     Month         |                        |                | 3. Time of Death                               |
| Medical Examin   | er             | Rafik  |                          | V                                   | 7 .           |                | Bagi              | rov                         | July 12, 20                    | Day \<br>106           | Year           | 2300 hrs                                       |
| (  |                | 4a. Facility Name (if not ins                              | itution, give stre       | eet and number)                     |               |                | 4b. City, Tow     | n, or Location of D         | eath                           | 4c. Coun               | ty of Death    |  |
| -  |                | 3601 Fords Lane  |                          |                                     |               |                | Batimore          | e                           |                                |                        |                |  |
| Funeral  | ╗              | 5. Social Security Number                                  | 6. Sex                   | 7. Ag                               | e (In yrs. la | st birthday)   | If Under 1        | Year If Under 24            | 4Hrs. 8. Date of Birt          | h(MM/DD/YY             | YY 9. Birth    | place (State or                                |
| Director   | - 1            | 012-78-117   | 5 1X M                   | 2 F                                 | 75            | Y              | Months            | Days Hours                  | Min. [03 0]                    | 31                     | Foreigr<br>Cou | ntry) Russia                                   |
|  | H              | Usual Residence of Decede                                  | -                        |                                     | 13            |                |                   |                             | <u> </u>                       |                        |                | Rabbia   |
| any  | ı              | 10a. State 10b. Co   |                          |                                     | 10c. City,    | Town or Loc    | ation             |                             |                                |                        | Í              | 10d. Inside City Limits                        |
| <u></u>  | ٠l             | MD   | NA                       |                                     | "             | ltimo          | 220               |                             |                                |                        |                | 1 X Yes 2 No                                   |
| rylan<br>a-fs  | 읤              | 10e. Street and Number                                     | IVA                      |                                     | _ Ба          | TCIM           | 10f. Zip Co       | de                          | 110                            | g. Citizen of          | What Coun      | trv?   |
| r death with the Maryland<br>or items 23a or 28a-f show<br>must be notified at once.   | Director       | 0.003 - 3  | _                        |                                     |               |                |                   |                             |                                | -                      |                |  |
| ith th   |                | 3601 Fords   |                          | . Was Decedent                      | Everin II 6   | . 142 14       | /as Dasadani s    | 21215                       | ( Specify Yes or No-           | Russ                   |                | on Indian Black                                |
| tems   | Funeral        | 1 Never Married 2  | Married .                | Armed Forces                        |               |                |                   | uban, Mexican, Pu           |                                |                        | hite, etc.     | can Indian, Black,                             |
| or i   |                | 3 Widowed 4 ¥  | Divorced If Ye           | Yes 2                               | X No          | 1,5            | V 1 W             | No specify:                 |                                |                        | W              | hite   |
| rs aft<br>araf"  | [호             | 15. Decedent's Education                                   |                          | Jates:                              | nnieted)      |                |                   | cupation (Give kind         | of work done                   | Specif<br>16b. Kind of |                | duotni   |
| hou:   | eted           | Elementary/Secondary (                                     |                          | College (1-4 or                     |               |                |                   | g life. DO NOT use          |                                | TOD. KING OF           | Dusinessin     | ludstry  |
| 36<br>in 72<br>han   | 읦              |  | .                        | • •                                 | ···           | <b>17</b> .    |                   |                             |                                |                        |                | <b>a</b>                                       |
| With With  | Comp           | 12th grade 17. Father's Name (First, M                     |                          | 4yrs                                |               | EI             | nginee            |                             | lame (First, Middle, N         |                        |                | Corp.  |
| f Hyy  | ျှ             |  | • •                      |                                     |               |                |                   |                             | •                              |                        | ine)           |  |
| 112<br>Aents<br>nark   | a<br>B         | Vahid Bagi 19a. Informant's Name/Rela                      |                          | Print \                             |               | 10h Maili      | na Address /      |                             | ma Bagir<br>or Rural Route Num |                        | Our State      | Zin Cada)                                      |
| Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranunatic event, the Medical Examiner must be notified at once. | 의              |  |                          | ,                                   |               | 10             | ,                 |                             |                                |                        | . ,,           | -,,  |
| md 2<br>salth  | ŀ              | Matlab Bag<br>20a. Method of Disposition                   | 1rov-s                   | 5011                                | 20h F         |                | osition (Name     |                             | Date                           | 20c. Locatio           |                | Md 21136                                       |
| Ores 1 a of He   | Ш              |  | nation 3                 | Removal from St                     |               | rematory or    |                   | or comotory,                | Date                           | 200. Localit           | on only or     | Town, State                                    |
| Page<br>Page<br>neut<br>ant:<br>or oth   | Ш              | 4 Donation 5 Oth   |                          |                                     |               | ng Me          | emoria            | 1 Park                      | 7/21/06                        | Randa                  | allst          | own, Md  |
| alti<br>mit.<br>partr<br>port<br>jury  |                | 21. Signature of Funeral Se                                | rvice Licensee           | 1                                   |               | M22            | Name and Ad       | dress of Facility<br>H West |                                |                        |                |  |
| <b>a</b> 89 <b>a</b> 1   |                | / als  | - YV                     | Carc                                | h             |                |                   |                             | e, Balti                       | more                   | - Md           | 21215  |
| Physician  |                | 23a art I. En er the disea failure. List only one          |                          |                                     | the death.    | Do not enter   | the mode of d     | ying, such as card          | iac or respiratory arre        | est, shock, or         | heart          | Approximate Interval<br>Between Onset and      |
| /Medical   |                | Immediate Cause (Final di                                  | 1.1                      | nie.<br>pertensive A                | therpscle     | erotic Car     | diovascular       | Disease                     |                                |                        |                | Death  |
| Examiner   |                | or condition resulting in de                               |                          | to (or as a cons                    |               |                |                   |                             |                                |                        |                |  |
|  |                | Sequentially list conditions                               | b                        |                                     |               |                |                   |                             |                                |                        |                |  |
|  | Examiner       | if any, leading to immediate<br>cause. Enter Underlying C  | ause                     | to (or as a cons                    | sequence of   | ):             |                   |                             |                                |                        |                |  |
| 1  | 핆              | (Disease or injury that initial events resulting in death) | ated C.                  | to (or as a cons                    | equence of    | \:             |                   |                             |                                |                        | -              |  |
| d d ansit  |                | events resulting in death)                                 | d.                       | ,                                   |               |                |                   |                             |                                |                        |                |  |
| e executed sian and rial - transit   | lical          | UNPENDED   | A                        | MENDED                              |               |                |                   |                             |                                |                        |                |  |
| ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be retent.  reter: After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the buri   | Physician/Med  | IF FEMALE:   | 1 2                      | 3c. If yes, outco                   | me of prear   | ancv           |                   |                             |                                | 23d Date               | e of delivery  |  |
| 87<br>tifica<br>ng pl  | Ž.             | 23b. Was decedent pregnar<br>past 12 months?               |                          | Live birth                          | inc or progr  |                | Fetal death       | 3 Ectopic pr                | egnancy                        | Month                  |                | ay Year  |
| × 6<br>th cer<br>tendi   | 흥              |  | 4                        | Pregnant a                          | t time of     |                | Other (Specify    | )                           |                                |                        |                |  |
| Box<br>e death c<br>the atten  | nys.           | 1 Yes 2 No 9   | Unknown g                | Unknown                             |               |                |                   |                             |                                |                        |                |  |
| d by   |                | Part II. Other significant of                              | onditions cor            | ntributing to dea                   | th but not re | sulting in the | e underlying ca   | iuse given in Part I        | . 23e. Did to                  | bacco use co           | ontribute to   | the cause of death?                            |
| of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by tuneral director, page 2 should be detach  | d by           |  |                          |                                     |               |                |                   |                             | 1 Yes                          | 2 No                   | 3 Prob         | ably 4 🗸 Unknown                               |
| of Vital Records, ig Physician: The law require Wither this certificate has been is meral director, page 2 should the  | Completed      |  |                          |                                     |               |                |                   |                             | 24a. Was                       |                        |                | topsy findings available ompletion of cause of |
| e law  | E d            | -  |                          |                                     |               | ,              |                   |                             |                                | med?                   | death?         |  |
| Re<br>ficate<br>f, pag   | ပိ             |  |                          |                                     |               |                |                   |                             |                                | 2 🗸 N                  | 1 Ye           | s 2 No   |
| certi  | Be             | 25. Was case referred to m<br>examiner?                    | Hosp                     | oital .                             |               |                |                   | Other N                     |                                |                        |                |  |
| Physical direction   | ပ္             | 1 Yes 2 N  |                          | ı ınpatı                            |               | ER/Outpatie    |                   | , , , , , ,                 | ursing Home 5                  | Residence              |                | : Scene  |
| Ing Afte   | Ë              | 27. Manner of Death  1 V Natural 5                         |                          | 28a. Date of Inj<br>(Month, Day,    | ury<br>Year)  | 28b. Time o    | of injury 280     | . Injury at Work?           | 28d. Describe                  | now injury occ         | curred         |  |
| tteng<br>death<br>rtor:  | ä              | 2 Accident   | Pending<br>Investigation |                                     |               | _              | 1                 | Yes 2 No                    |                                |                        |                |  |
| Division<br>tal or Attendi<br>rs after death.<br>al Director: A  | iji            | 3 Suicide 6  | Could not be             | 28e. Place of I                     | njury - At ho | me, farm, st   | reet, factory, of | fice building, etc.         | 28f. Location (S<br>or Town, S |                        | ımber or Ru    | ral Route Number, City                         |
| pital<br>Durs (  | Certification: | 4 Homicide   | determined               | (Specify)                           |               |                |                   | - <u>-</u>                  |                                |                        |                |  |
| Division of Vi To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di   | al             |  |                          |                                     |               |                |                   |                             | , and due to the caus          |                        |                |  |
| Fo the within Fo the compl   | Medical        | 2 Medica   | I Examiner: On<br>an     | the basis of exa<br>d manner stated | amination ar  | nd/or investig | gation, in my op  | oinion, death occur         | red at the time, date          | and place, ar          | nd due to the  | e cause(s)                                     |
| Fara   | ž              | 29b Signature and title of                                 |                          | ^                                   |               |                | 29c. L            | icense number               | -                              | 29d. Date s            | signed (Mor    | nth, Day, Year)                                |
| ,  |                | 1 () ax11  | Vaste                    | 4()                                 |               |                |                   | D.C.M.E.                    |                                | July 13,               | 2006           |  |
|  |                | 30. Name and address of p                                  | erson who                | pleted cause of                     | death (Item   | 23a)           |                   |                             |                                |                        |                |  |
| P  |                | Laron Locke MD.  |                          | t Medical Ex                        |               |                | nn Street, E      | Baltimore, MD               | 21201                          |                        |                |  |
| St   | ate            | 31. Date filed (Morith, Pay.                               | pear 2006                | 32/Registr                          | ar's Signatu  | * do           | all               |                             |                                |                        |                |  |
| Regist   |                | JUL  | 9 0 2000                 | Control of the Control              |               | 7              | 1000000           |                             |                                |                        |                |  |

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** July 19, Fannie L. Bischoff 9:40 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glynn Taff Assisted Living Catonsville Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 X F Yrs. Director 91 1914 Baltimore 217-03-8124 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits Itam 27 is marked other than "natural", or itama 23a or 28e-f show other traumatic event, the Medical Eventral must be notified at 1 ☐ Yes 2X No Maryland Baltimore Direct Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1403 Midvale Avenue 21228 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or its 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ρ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beautician Cosmetology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Tompkins Julia Raymond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If itam 27 is 1403 Midvale Avenue; Catonsville, MD 21228 et of Disposition (Name of Date 20c. Location - City or Town Raymond A. King Son 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 Cremation 3 Removal from State ö permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) 7/25/2006 Loudon Park Cem. Baltimore, Maryland 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final **Physician** Lancen-lung disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ putamen 1 Yes 2 No 3 Probably 4 GUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dinenta autopsy performed? 2 No 1 Yes 2 No 1 Tyes Hospital or Attending Physician: 24 hours after death. Funarel Diractor: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Dother (Specify ASS i Sted Ching 1 ☐ Yes 2 ☐ 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 -Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funerel D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7-19-2006 lewowid 1966 Willen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ritchie Hillway # 508 Glen Sorver Co susum 7310 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2 0 2006 DEALL JUL Registrar

|                            |  |                     | For<br>State<br>Registrar  | State of Ma   | -                                      | -                          | tment of H                                 |                                      |  | giene                         | 006                          | 22707  |
|----------------------------|--|---------------------|--|---|--|----------------------------|--|--------------------------------------|--|-------------------------------|------------------------------|--|
|                            | Physici  | an                  | 1. Decedent's Name (First, Middle, Last)   |   |  |                            |  |                                      | 2. Date of De.                             |                               | Year                         | 3. Time of Death                               |
|                            | /Medic   | al .                | Barbara V. Baader  |   |  | 4                          | b. City, Town, or                          | Lagation of Do                       |  |                               | nty of Death                 | 10:53 P. <sup>M</sup>                          |
|                            | Examin   | er                  | 4a. Facility Name (If not institution, give s<br>Charlestown Care  |   |  | 4                          | Catons                                     |                                      | atri                                       |                               | ltimor                       | re.  |
|                            | Funeral  |                     | Social Security Number 6. Sex  | 7. Age  | (In yrs. last bir                      |                            | f Under 1 Year                             | If Under 24 Hr                       |  | th                            | 9. Birtho                    | place (State or Foreign                        |
|                            | Director   |                     | 212-26-0936  | M 2\\ F 7   | 6                                      | Yrs.                       | Months Days                                | Hours Mir                            |  | 18,1929 Maryland              |                              |  |
|                            | pu k   |                     | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, Town                        | n or Locat                 | rion                                       |                                      |  |                               | 1                            | IOd. Inside City Limits                        |
|                            | Maryli<br>f sho  | ō                   | Maryland Baltimore   | e   | Caton                                  |                            |  |                                      |  |                               |                              | 1 ☐ Yes 2 ☑ No                                 |
|                            | r 28a-   | rect                | 10e. Street and Number   |   |  |                            | 10f. Zip Code                              |                                      |  | 10g. Cilizen o                | of What Cour                 | ntry?  |
|                            | th with  | al D                | 709 Maiden Choice  | Lane #208   | S                                      |                            | 21   | 228                                  |  | USA                           |                              |  |
|                            | ems ;  | iner                | 11. Marital Status   | 2. Was Decedent E<br>Armed Forces?                              | ver in U.S.                            | 13. Wa                     | s Decedent of His                          | spanic Origin?                       | (Specify Yes or No<br>erto Rican, etc.)    | - 14. R                       | lace - Americ                |  |
| 36                         | within 72 hours after deeth with the Maryland<br>ene.<br>than "natural", or Items 23a or 28a-f show<br>the Madical Exeminer mant be colified at  | by Funeral Director | 1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 🔼 N<br>If Yes, Give                                   | 0                                      |                            |  | Specify:                             |  | Spec                          | T                            | White  |
| 21215-0036                 | hour   | ed b                | 15. Decedeni's Educ  | Year or Dates:  | 16a.                                   | Deceden                    | it's Usual Occupa                          | tion                                 |  | 16b. Kind of                  | Business/In-                 | dustry   |
| 15                         | nin 72<br>n ne   | Completed           | (Specify only highest grade  |   |  | (Give kin                  | d of work done d<br>NOT use retired)       | uring most of w                      | orking                                     |                               |                              |  |
| 212                        | giene<br>giene<br>er ths   | E O                 | Elementary/Secondary (0-12)  | College (1-40) 5  | C                                      | ustor                      | ner Serv                                   | ice Rep                              | •  | Teleph                        | none                         |  |
| p                          | be file<br>tal Hy<br>d oth   | Be                  | 17. Father's Name (First, Middle, Last) George Vickers   |   |  |                            |  |                                      | <sub>ame (First, Middle,</sub><br>olaschek | Maiden Sum                    | ame)                         |  |
| yla                        | d Men<br>narke   | <sup>L</sup>        |  | Defeat)   | 105                                    | A 4 = 10 = = =             | A 44 (Green                                |                                      |  | - C' T                        | - C                          | 0-1-1  |
| Maryland                   | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat, or tiems 23a or 28a-1 show simportant: if item 27 is marked other than "naturat, or tiems 23a or 28a-1 show simply or other traumatic event, the Madical Examinat must be notified at QDCs. |                     | 19a. Informant's Name/Relationship (Typ.   | Step So:  |  |                            |  |                                      | Rural Route Numbe<br>Catonsvi              |                               |                              |  |
| ē,                         | Heal<br>Heal<br>tem 2  |                     | Craig R. Baader  20a. Method of Disposition  |   | 20b. Place of                          | Dispositi                  | on (Name of                                |                                      | Date                                       |                               | n - City or To               |  |
| <u>o</u> E                 | ages<br>ent of<br>ht: if if  |                     | 1 Burial 2 Cremation 3 Re<br>4 Donation 5 Other (Specify)  | emoval from State   | 1                                      |                            | ony or other place                         | 1                                    | 1/2006                                     | Flbrid                        | ico M                        | aruland  |
| Baltimore,                 | partm<br>partm<br>portsi<br>y inju   |                     | 21. Signature Ineral Service Licens  | /   | picadow                                | 22. N                      | lame and Addres                            | s of FacilitySt                      | erling A                                   | shton S                       | Schwab                       | Witzke   |
| ä                          | Departiment in post in sny ir  |                     | Y with   | 1   |  | 16                         | ineral H<br>630 Edmo                       | ome or<br>ndson A                    | Catonsvi.<br>venue: Ca                     | lle,Ind<br>atonsvi            | ille.                        | MD 21228                                       |
|                            |  |                     | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on   | cations that caused<br>e cause on each lin                      | the death. Do i                        |                            | the mode of dying                          | , such as cardi                      | ac or respiratory ai                       |                               |                              | Approximate<br>Interval Between                |
|                            | Physician  |                     | Immediate Cause (Final disease or condition  |   | Vag                                    | ina                        | ٨ (  | 911(6                                |  |                               |                              | Onset and Death                                |
|                            | /Medical<br>Examiner   |                     | resulting in death)  | Due to (or as a   | consequence                            | of):                       |  |                                      |  |                               |                              |  |
| ı                          |  | -                   | Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying   | Due to for es a   | consequence                            | on:                        |  |                                      |  |                               |                              |  |
| 6                          | uted<br>d<br>ansit   | m<br>L              | Cause (Disease or injury   | `   |  |                            |  |                                      |  |                               |                              |  |
| ٥,                         | exection and and rial-tra  | Examiner            | resulting in death) Last   | Due to (or as a   | consequence                            | of):                       |  |                                      |  |                               |                              |  |
| 8760,                      | death certificate be executed e ettending physicien and ind for use es the burial-transit  | dical               | d  |   |  |                            |  |                                      |  |                               | _                            |  |
| 9                          | leath certifica<br>ettending ph<br>I for use es ti   | Med                 | IF FEMALE:   |   | ************************************** |                            |  |                                      |  | +                             |                              |  |
| Box                        | ath co   | lan/                | 23b. Was decedent pregnant in the past 12 months?  | 3c. If yes, outcome of<br>1 ☐ Live birth<br>4 ☐ Pregnant at     | 2 Fetal death                          |                            | ctopic pregnancy                           |                                      |  |                               | Date of delive<br>Month      | ery<br>Day Year                                |
| o.                         |  | Physician/Med       | 1 ☐ Yes 2 ☎No<br>9 ☐ Unknown   | 9□ Unknown  | time or death                          | 2 0                        | ther (specify)                             |                                      |  |                               |                              |  |
| <b>Q</b>                   | requires thet the<br>leen signed by th<br>hould be detache   | y Ph                | Part II. Other significant conditions con  | tributing to death bu   | it not resulting in                    | n the unde                 | erlying cause give                         | n in Part I.                         | 23e. Did to                                | obacco use co                 | ontribute to th              | he cause of death?                             |
| rds                        | quires<br>nn sign<br>uld be  | ed by               |  |   |  |                            |  |                                      | 10   | res ANNO                      | 3 ☐ Prob                     | pably 4 □Unknown                               |
| 000                        | a ₹  | Completed           |  |   |  |                            |  |                                      | 24a. Was                                   |                               | b. Were auto                 | psy findings available<br>mpletion of cause of |
| ž                          | The<br>ete h   | E O                 |  |   |  |                            |  |                                      |  | rmed?                         | death?                       |  |
| /ita                       | Physicien: Th<br>this certificete<br>ral director, pag   | Be (                | 25. Was case referred to medical examiner?   |   |  |                            |  |                                      | eath Check only o                          | ne)                           |                              |  |
| )<br> <br>                 | w 5  | ဥ                   | TLI THIS ZOLING  | ospital: 1 ☐ Inpatie  |  | · -                        | 3 DOA Othe                                 | 4 AU NUISING                         | Home 5 ☐ Resid                             |                               |                              | y)   |
| no                         | ding Ph.<br>h.<br>After thi<br>funeral   | lo                  | 27. Manner of Death  De | 28a. Dale of Injur<br>(Month, Day                               |  | Time of<br>Injury          | 28c. Injury<br>Work                        | at<br>?<br>Yes 2 □ No                | 28d. Describe I                            | 10w injury occ                | currea                       |  |
| Division of Vital Records, | or Attending<br>after death.<br>Director: After<br>In by the fune  | fica                | 3 Suicide 6 Could not be   | 28e. Place of Inju  | rry - At home, fa                      | arm, sireet                |  |                                      |  |                               | mber or Rura                 | al Route Number,                               |
| Ö                          | s after<br>i Dire  | Certification;      | 4  Homicide determined   | building, etc   | (Specify)                              |                            |  |                                      | City or Tov                                | vn, State)                    |                              |  |
|                            | To the Hospital or Attention within 24 hours after deat To the Funeral Director: completely filled in by the   | edical (            | 29a. Certifier Check only one) Certifying Phys   | ician: To the best of<br>ier: On the basis of<br>and manner sta | examination an                         | e, death or<br>nd/or inves | ccurred at the time<br>stigation, in my op | e, date and pla-<br>pinion, death oc | ce, and due to the<br>curred at the time,  | cause(s) and<br>date and plac | manner as s<br>e, and due to | tated.<br>the cause(s)                         |
|                            | To the within 2 To the complet   | Me                  | 29b. Signature and title of certifier  |   |  |                            | 29c. License                               | number                               |  | 29d. Date sig                 |                              |  |
| )                          |  |                     | 1  | MD  |  |                            | DY   | 744                                  | /  | 1-1-                          | 18                           | , 2006   |
|                            | 5  |                     |  | 715   | )(\ N                                  | (Type, Pri                 | h (he                                      | no le                                | ing (                                      | J-ly<br>aten                  | SU! 1                        | u  |
|                            | Sta<br>Registi   |                     | 31. Date filed (Month, Day, Year)  JUL 2 0 200   | 102   | ar's Signature                         | los                        | de   |                                      |  |                               | •                            |  |

DHMH 17 Rev 1/2001

ORIGINAL

|             |  |                     | 1 = For<br>State<br>Registrar  | State o                                   | f Maryland  |                                | artment of H<br>rtificate of L                                    |  | d Ment                      | tal Hygien<br>Reg. N                            | Z 11116                                       | 22708  |  |  |
|-------------|--|---------------------|--|---|---|--------------------------------|---|--|-----------------------------|---|---|--|--|--|
| ı           | Physici<br>/Medic  |                     | Decedent's Name (First, Middle   | -,,                                       | ura Sue   |                                |   |  | ay Year<br>7, 2006          | 3. Time of Death<br>7:20 p M                    |   |  |  |  |
| ı           | Examin   |                     | 4a. Facility Name (If not institution  | n, give street and nui<br>r Health & Reh  | •   | ville                          | 4b. City, Town, or  |  | eath<br>altimore            | 4c. County of Death  Baltimore                  |   |  |  |  |
| Ī           | Funeral<br>Director  |                     | 5. Social Security Number 217-26-0522  | 6. Sex<br>1 □ M 2√□ F                     | 7. Age (In yrs. Ia  |                                | If Under 1 Year<br>Months Days                                    | If Under 24                                | Hrs. 8. D                   | ate of Birth<br>Month, Day, Year<br>Oct 29, 193 | Year) Country)                                |  |  |  |
|             | yland<br>now   |                     | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City,  | Town or Lo                     | cation  |  | 10d. Inside 0               |   |   |  |  |  |
|             | he Mar<br>8a-fsl   | ector               | Maryland   | N/A                                       |   |                                |   | ltimore                                    |                             |   |   | 1 K Yes 2 □ No                                     |  |  |
|             | h with th  | al Dir              | 10e. Street and Number  220 North Hilton Stre  | eet                                       |   |                                | 10f. Zip Code   | 21229                                      |                             | 10g. C  | itizen of What Cou                            | -  |  |  |
| 36          | perriit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating matter routing any once. | by Funeral Director | 11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced  | ried Armed Fo                             | 2 ⋈ No<br>ve  |                                | Was Decedent of Hi<br>f Yes, specify Cuba<br>1 ☐ Yes 2 🙀 No       | spanic Origin<br>n, Mexican, P<br>Specify: | ? (Specify \uerto Ricar     | Yes or No-<br>n, etc.)                          | 14. Race - Ameri<br>Black, White,<br>Specify: |  |  |  |
| 21215-003   | ithin 72 hou<br>ne.<br>nan "natura<br>e Mudical E  | Completed I         | 15. Deceder  | t's Education<br>st grade completed)      |   | (Give                          | dent's Usual Occupa<br>kind of work done o<br>DO NOT use retired, | uring most of                              | working                     |   | Kind of Business/Ir                           | ·  |  |  |
|             | filed w<br>Hygier<br>other th  | Be Cor              | 12. Father's Name (First, Middle,  | Last)                                     |   |                                |   | thef<br>18. Mother's                       | Name (Firs                  | st, Middle, Maide                               |   |  |  |  |
| Maryland    | Mental<br>Mental<br>Brked (  | To B                | L  | Inknown                                   |   |                                |   |  |                             | Fannie  | James   |  |  |  |
| Mar         | d 2 sho<br>th and<br>t7 Is mu<br>traum   |                     | 19a. Informant's Name/Relations Floyd Beasley Husb   |   |   |                                | ng Address (Street a  |  |                             |   |   | o Code)  |  |  |
| altimore,   | Pages 1 an<br>lent of Heal<br>nt: If item 2<br>ry or other   |                     | 20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (S                            | 3 □Removal from                           | Citato  | ice of Dispo                   | sition (Name of<br>natory or other place<br>rest Veterans         | 9)   | Date                        |   | ocation - City or T                           |  |  |  |
| Balti       | permit. Departm Importe any inju   |                     | 21. Si na ure il nuneral Service   |   | Este  |                                | . Name and Addres<br>Estep Br                                     | s of Facility others Fu                    | ineral S                    | ervice, P. A.<br>ore, Md 212                    | 17  |  |  |  |
| İ,          | 1  |                     | 23a. Part1. Enter the disease, or<br>shock, or heart failure. List   | complications that of only one cause on e | aused the death.  | Do not ent                     | er the mode of dying  | , such as car                              | diac or resp                | piratory arrest,                                |   | Approximate<br>Interval Between<br>Onset and Death |  |  |
| ı           | Pnysician /<br>/Medical  |                     | Immediate Cause (Final disease or condition resulting in death)  | a   | (or as a consequ  | 1 5 P                          | inte,   | myc  | reup                        | yc C  | ancer   | 140  |  |  |
|             | Examiner   | Examiner            | Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b   | (or as a conseque   | n th                           | ewseli  | ntie                                       | he                          | eme   |   | 5445   |  |  |
| 8760,       | icate be executed<br>physician and<br>s the burial-transit   | edicai Exa          | that initiated events resulting in death) Last   | Due to                                    | (or as a conseque   | ence of):                      |   |  |                             |   |   |  |  |  |
| Box 6       | The law requires that the death certifica<br>ate has been signed by the attending ph<br>bage 2 should be detached for use as th  | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown                      | 1 ☐ Live t                                | tcome of pregnan<br>pirth 2  Fetal cannot at time of deco | death 3                        | Ectopic pregnancy   |  |                             |   | 23d. Date of delivership                      | ery<br>Day Year                                    |  |  |
| rds, P.O    | w requires that t<br>been signed by<br>should be detar   | by                  | Part II. Other significant conditi   | ons contributing to de                    | eath but not resul  | ting in the u                  | nderlying cause give  | n in Part I.                               | 2                           | 23e. Did tobacco<br>1 ☐ Yes 2                   | use contribute lo t                           | he cause of death?                                 |  |  |
| al Records, | ysicien: The law requis certificate has been director, page 2 should   | Completed           |  |   |   |                                |   |  | -                           | 24a. Was an autopsy performed?                  | prior to co<br>death?                         | psy findings available mpletion of cause of        |  |  |
| Vita        | ysicien: Th<br>s certificate<br>director, pag  | To Be               | 25. Was case referred to medical examiner?  1  Yes 2 No  | Hospital-                                 | Inpatient 2□E   | R/Outpatien                    | t 3 DOA Othe  | 26. Place of                               |                             |   | 6 ☐Other (Specif                              | (v)  |  |  |
| Division of | 유 글 등  | ertification: T     | 27. Manner of Death  1 Natural 5 Pendir 2 Accident investi   | 28a. Date<br>(Mon                         |   | 28b. Time <i>o</i> f<br>Injury | 28c. Injury<br>Work   |  |                             | Describe how inju                               |   | ,  |  |  |
| Divis       | ital or Atters as after de al Directo  | Certific            | 3 Suicide 6 Could 4 Homicide determ  | ined 286. Place                           | of Injury - At honing, etc. (Specify)                     | ne, farm, str                  | eet, factory, office  |  |                             | ocation (Street a.<br>lity or Town, State       | nd Number or Rura<br>e)                       | al Route Number,                                   |  |  |
|             | To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, g  | Medical             | (Check onto 2 Medical one)   |   | best of my know<br>asis of examinationer stated.          | ledge, death<br>on and/or inv  | estigation, in my op  | inion, death o                             | lace, and di<br>occurred at | the time, date an                               | d place, and due to                           | o the cause(s)                                     |  |  |
| ł           | To vitt  | 2                   | 29b. Signature and title of certifie   | In  | - Al  | buer                           | 29c. License  | 79   | 769                         | 29d. Da   | ate signed (Month, $\frac{1}{2}$              | Day, Year)   |  |  |
|             | $0_j$  |                     | 30. Name and address of person   | who completed caus                        | se of death (Item:  | 23a) (Type,                    | 5/6N.   | R.//                                       | 1/aa                        | pl A  | m/1 1   | 2/228  |  |  |
|             | Sta<br>Registi   | -                   | 31. Date filed (Month, Day, Year,  | 2006 32                                   | egistrar's Signatu  | 12 6                           | redi  |  | 8                           |   | NIN   | 7  |  |  |

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** BROPHY JULY 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE HARBOR HOSPITAL, 3001 S. HANOVER ST BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country). Florida 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1/XM 2 ☐ F 219 50 0395 59 Director June 6.1947 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend. Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "nature" ery injury or other treumatic executions. 10a State 10b Counts 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Anne Arundel Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 307 Moonlight Court 21225 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Clerk Glass Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Evelvn Schait Richard R. Brophy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Brophy / Brother 307 Moonlight Court Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 7/18/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee monurourfu 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DIABETES MELLITUS) TYPE 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physicien and s the burial-transit The law requires that the death certificate be executed ANEMIA that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, RENAL FAILURE Physician/Medical use as the attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown *eukocytosis* Completed peeu DRINARY TRACT INFECTION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed MYELODYSPLASTIC SYNDROME certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient ဥ 2 ER/Outpatient 3 DOA this Director: After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) atel, MD 228536 JULY, 15, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S. HANOVER ST, BALTMORE, MI) SEJAL PATEL, HARBOR HOSPITAL
31. Date filed (Month, Day, Year)
32. Register's Signature State JUL 2 0 2006

DHMH 17 Rev 1/2001

Registrar

|                            |   |                               | 1 - For<br>State<br>Registrar  | State of Marylai   | •                                    | artment of F  |                                |                                       | giene<br>Reg. No. 2006                      | 22711   |
|----------------------------|---|-------------------------------|--|--|--------------------------------------|---|--------------------------------|---------------------------------------|---|---|
|                            | Physici<br>/Medio   | al                            | 1. Decedent's Name (First, Middle, Las<br>REGINALD  4a. Facility Name (If not institution, give  | BROOKS   |                                      | 4b. City, Town, o   | r Location of Dea              | 2. Date of De Month                   | Day Year 13 06 4c. County of Dea            |   |
|                            | Examir<br>Funeral<br>Director   | ier                           | METRO TRANSITI   | ONAL CENTE   | ER<br>. last birthday)<br>UL Yrs.    |   | TIMOR If Under 24 Hr Hours Mir | s. 8. Date of Bir<br>(Month, Da       | th 9. Bir                                   | hthplace (State or Foreign ountry)                      |
|                            | D D   | tor                           | Usual Residence of Decedent  10a. State  10b. County  MD N/A   | 10c. C   | ity, Town or Lo                      | ocation<br>JTIMORE  |                                | 01 1                                  | 8 60 MA                                     | 10d. Inside City Limits                                 |
|                            | with the<br>a or 28a  | Direc                         | 10e. Street and Number   | 7 DOAD   | DAL                                  | 10f. Zip Code   | 10                             |                                       | 10g. Citizen of What Co                     | ountry?   |
| 036                        | s 1 end 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene flem 27 ie marked other then "natural; or iteme 23a or 28a-f ehow other treumatic event, the Medical Evential the notified at | Completed by Funeral Director | 1652 SHADYSIDI  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 2 ☒ No<br>If Yes, Give<br>Year or Dates:  |                                      | 212 Was Decedent of H If Yes, specify Cuba                    |                                | Specify Yes or No<br>rto Rican, etc.) | USA 14. Race - Am. Black, Whi Specify: 31   | te, etc.  |
| 21215-0036                 | ad within 72 ho<br>giene.<br>er then "natur.<br>i, the Medical I  | completed                     | 15. Decedent's Ed<br>(Specify only highest gra<br>Elementary/Secondary (0-12)<br>12TH  |  | 16a. Dece<br>(Give<br>iife.          | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | eation<br>during most of wi    |                                       | 16b. Kind of Business                       | s/Industry  |
|                            | d be filed<br>ental Hygis<br>ked other<br>c event, II   | To Be C                       | 17. Father's Name (First, Middle, Last)  WILLIAM H. BRO  | OOKS   |                                      |   |                                | nme (First, Middle<br>RINE KE         | , Maiden Sumame)<br>ARSON                   |   |
| , Maryland                 | end 2 should be ealth and Mental In 27 ie marked o  | -                             | 19a. Informant's Name/Relationship (7) CATHERINE BROOM   | ype, Print)  |                                      | _   | and Number or F                | Rural Route Numb                      | er, City or Town, State,                    | . *   |
| nore                       | ages 1 en<br>int of Heal<br>it: if item 2<br>y or other   |                               | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Denation 5 ☐ Other (Specify   | Removal from State   | Place of Dispo<br>cemetery, creating | osition (Name of matory or other place                        |                                | Date<br>LY 25,2                       | 20c. Location - City or                     | Town, State   |
| Baltimore,                 | permit. Pages 1 en<br>Depertment of Heal<br>Important: if item 2<br>eny injury or other<br>ance.  |                               | 21. Senture of Funeral Service Licen   | - / //   | 2                                    | 2. Name and Addre   | ss of Facility<br>SCRUG        | GS FUNE                               | RAL HOME                                    |   |
|                            | Physician<br>/Medical   |                               | 23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)                   | plications that caused the deapne cause on each line.  FND STACE  a.  Due to (or as a conse  | IRED !                               | ter the mode of dyin  | ng, such as cardia             | ac or respiratory a                   | LTO, MD. 2 rrest, YNDROME                   | Approximate<br>Interval Between<br>Onset and Death      |
| 8760,                      | e be executed /sicien and e burial-transit  | dical Examiner                | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conse  | quence of):                          | TIFOCA  | L LEUK                         | oencep.                               | HALOPATHY                                   |   |
| P.O. Box 6                 | at the death certifical<br>by the attending phy<br>tached for use as th   | Physician/Med                 | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown   | 23c. If yes, outcome of pregr<br>1 □ Live birth 2 □ Fet<br>4 □ Pregnant at time of<br>9 □ Unknown  | al death 3                           | Ectopic pregnancy Other (specify)                             | ′                              |                                       | 23d. Date of de<br>Month                    | Day Year  |
|                            | iaw requires thet the<br>as been signed by th<br>2 should be detache  | by                            | Part II. Other significant conditions of   | ontributing to death but not re  | sulting in the u                     | inderlying cause giv  | en in Part I.                  |                                       | obacco use contribute t<br>Yes 2 No 3 P     | to the cause of death?                                  |
| Division of Vital Records, | The<br>ate h  | <b>Completed</b>              | 25. Was case referred to medical   |  |                                      |   | 00 81                          | 1 ☐ Yes                               | psy prior to death?                         | utopsy findings available completion of cause of s 2 No |
| of Vil                     | Physician:<br>this certificant  | To Be                         | examiner?<br>1 X Yes 2 □ No  |  | ☐ ER/Outpatie                        |   | er: 4 Nursing                  |                                       | dence 6 SOther (Spe                         |   |
| ision (                    | ding<br>Aftar<br>fune   | Certification;                | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be   |  | 28b. Time o<br>Injury                | M 1   | yat<br>k?<br>Yes 2 □ No        |                                       | how injury occurred  Street and Number or R | INFIRMARY   |
| Ď                          | To the Hospital or Attent within 24 hours aftar death To the Funeral Director: completely filled in by the  |                               | 4 Homicide determined  | building, etc. (Spec   | ify)                                 |   |                                | City or To                            | wn, State)                                  |   |
|                            | the Hos<br>iin 24 hc<br>the Fun<br>ipletely   | ledical                       | (Check only 2 Medical Examone)   | yuician: To the best of my kn<br>niner: On the basis of examin<br>and manner stated.   | ation and/or in                      | vestigation, in my o  | pinion, death occ              | curred at the time,                   | date and place, and du                      | e to the cause(s)                                       |
|                            | To the To the comple  | 2                             | 29b. Signature and title of certifier  | B. Tel   | la                                   | 29c. Licens   | 4656                           | 7                                     | 29d. Date signed (Mon                       | 113106  |
|                            | H   |                               | 30. Name and address of person who TADESE 35 E 31. Date filed (Month, Day, Year)   | completed cause of death (Ite  | 9                                    | Print) MET<br>54 FOR  | RO TRI                         | ANSITIO<br>TREET                      | NAL CEN<br>BALTIMO                          | REMD21282   |
|                            | Sta<br>Regista  |                               | JUL 2 0 20   | THE STATE OF THE S | H A                                  | caeli I   |                                |                                       |   |   |

|  |  |                  | For<br>State<br>Registrar  |                                  | State                     | of Marylar   |                                   | artment of<br>rtificate o              | Health an<br>of Death   | nd Menta            | ll Hygien<br>Reg. No                     | 711116  | 22712  |  |
|--|--|------------------|--|----------------------------------|---------------------------|--|-----------------------------------|--|---|---------------------|--|---|--|--|
|  | Physici  |                  | 1. Decedent's Name<br>KHANA  | (First, Middle,                  | Last)                     |  |                                   | BURSI                                  | ζΔΥΔ  | 2. Dat<br>Mo<br>JUL | e of Death<br>nth Da<br>Y 17             | 2006  | 3. Time of Death 6:25 P M                        |  |
| i (in  | /Medio<br>Examin   |                  | 4a. Facility Name (If  | not institution, g               | give street and n         | rumber)  |                                   |  | n, or Location of D   |                     |  | : County of Death                             | 0.23 F   |  |
|  |  | Ages<br>1        | JEWISH CO  |                                  |                           |  |                                   | BALTI                                  |   | Hes I a s           |  | BALTIMORE                                     |  |  |
|  | uneral<br>irector  |                  | <ol> <li>Social Security Nu</li> <li>220-29-33</li> </ol>                |                                  | .Sex<br>1□M 2∏F           | 7. Age (In yrs.<br>87                                  | Yrs.                              | If Under 1 Ye Months Da                |   | Min. (Mo            | e of Birth<br>Inth, Day, Year<br>10/1918 | 9. Birth                                      | place (State or Foreign<br>ntry)<br>UKRAINE      |  |
| put  | 3  |                  | Usual Residence of D   | Decedent<br>10b. County          |                           | 10c. Ci  | ty. Town or Lo                    | cation                                 |   |                     |  | 10d. Inside City Limits                       |  |  |
| Maryla   | - a ho   | ţō               | MD   | BALTI                            | MORE                      |  | BALTIM                            |  |   |                     |  |   | 1 ☐ Yes 2 No                                     |  |
| th the   | or 286   | Olrec            | 10e. Street and Num  |                                  |                           |  |                                   | 10f. Zip Cod                           | ө   |                     | 10g. C                                   | itizen of What Cou                            | ntry?  |  |
| aath wi  | n 23a  | Funeral Director | 7920 SCO   | TTS LEV                          |                           | andert Ever in I                                       | 10 10                             | 2120                                   |   | 2 /Canada Va        |  | U.S.A   |  |  |
| 5-0030<br>72 hours after death with the Maryland                                       | 'natural', or itema 23a or 28e-f ahow<br>offal Examinat man by colline at                                | by               | 11. Marital Status 1 ☐ Never Marrie 3 ☑ Widowed 4                        |                                  | Armed                     | 2 🗆 No   |                                   | f Yes, specify C                       | of Hispanic Origin<br>Juban, Mexican, P<br>No <i>Specify:</i> | Puerto Rican, (     | etc.)                                    | 14. Race - Ameri<br>Black, White,<br>Specify: |  |  |
| 72 ho  | "natural",<br>adical Exe   | eted             | (Specif  | 15. Decedent's<br>y only highest | Education grade completed | d)   | 16a. Dece                         | dent's Usual Oc<br>kind of work do     | cupation<br>ne during most of<br>tired)                       | f working           | 16b. h                                   | Kind of Business/In                           | dustry   |  |
| filed within Hygiene.  |  | Completed        | Elementary/Segon   | dary (0-12)                      | College                   | (1-4or 5+)   |                                   | RETARY                                 | tired)  |                     |  | FACT  | 0RY  |  |
| be filed   | item 27 is markad other than<br>other traumatic avant, ma M  | BeC              | 17. Father's Name (F   | First, Middle, La                | ist)                      |  |                                   |  | 18. Mother's  | Name (First,        | Middle, Maidei                           | n Sumame)                                     |  |  |
| Men  | markad<br>matic av   | T <sub>O</sub>   | SOLOMON  19a. Informant's Nar  | /Dalatia ashi                    | Cons. Crist               |  |                                   | SSER                                   | MALK  |                     | 11 1 0"                                  |   | LANSKAYA   |  |
| O 40   | 27 is m<br>r traum   |                  | FELIX BUF  |                                  |                           |  |                                   |  |   |                     |  | or Town, State, Zip<br>E, MD 21:              |  |  |
| 0 -  |  |                  | 20a. Method of Dispo   |                                  | □ Removal from            |  | Place of Dispo                    | sition (Name of<br>natory or other     |   | Date                |  | ocation - City or To                          |  |  |
| altimo   | dury   |                  | 4 Donation   | 5 Other (Spe                     | city)                     | BAL  |                                   |  | CONG 07   | /19/200             | D6 REI                                   | STERSTOW                                      | N, MD  |  |
| December 1   | any ir   |                  | 21. Signature of Fun   | all I                            | - CI                      | tter   |                                   |  |   |                     |  | & BROS.,                                      |  |  |
|  | 2 (4   |                  | 23a. Part1. Enter the<br>shock, or heart                                 | e disease, or co                 | omplications tha          | t caused the dea                                       | th. Do not ent                    | er the mode of                         | tying, such as car  | rdiac or respir     | - PIKE<br>atory arrest,                  | SVILLE,                                       | Approximate<br>Interval Between                  |  |
|  | sician   |                  | Immediate Cause (F<br>disease or condition<br>resulting in death)        | inal                             | a. Er                     | a Sta  | Me R                              | enal'                                  | Discus  | e                   |  |   | Onset and Death                                  |  |
|  | edical<br>iminer   |                  | resulting in death)  | 1                                | Due t                     | o (or as a consec                                      | quence of):                       |  |   |                     |  |   |  |  |
| T. V   | /=   | ner              | Sequentially list con-<br>if any, leading to immo<br>cause. Enter Underl | ditions,<br>nediate<br>ving      | b. Due t                  | o (or as a consec                                      | quence of):                       |  |   |                     |  |   |  |  |
| executed   | rrans  | Examiner         | Cause (Disease or in<br>that initiated events<br>resulting in death) La  | njury                            | c                         | o (or as a consec                                      | allence of):                      |  |   |                     |  |   |  |  |
| oo / ou,   | physicien and stransit is the burial-transit   | edical E         |  |                                  | d say.                    | 0 (01 40 4 001100                                      | 4401100 01).                      |  |   |                     |  |   |  |  |
| rificat  | ng phy<br>as the   |                  | IF FEMALE:   |                                  |                           |  |                                   |  |   |                     |  |   |  |  |
| The law requires that the death certi  | been signed by the attending<br>should be detached for use a   | Physician/M      | 23b. Was decedent in the past 12 m                                       | ponths?                          | 1 🗆 Live                  | outcome of pregn<br>birth 2 Feta<br>gnant at time of c | al death 3                        | Ectopic pregna                         |   |                     |  | 23d. Date of deliver                          | ery<br>Day Year                                  |  |
| j 🖁  | ached  | hysic            | 1 ☐ Yes 2 D<br>9 ☐ Unknown   | <b>10</b> 0                      | 9□ Uni                    |  | 164III 2                          | Other (specify                         | /   |                     |  |   |  |  |
| es tha   | gned be det  | by P             | Part Other signific  | cant condition                   | s contributing to         | 1)   | _                                 | nderlying cause                        | given in Part I.  | 23                  |  |   | he cause of death?                               |  |
| he law requires  | peen s   | eted             | Lorona   | MY                               | ricry                     | 1)1340   | -15                               |  |   | _                   |  | 1   | bably 4 □Unknown                                 |  |
| he la  | e has  | Completed        |  | -                                |                           |  |                                   |  |   | _                   | a. Was an<br>autopsy<br>performed?       | prior to co<br>death?                         | opsy findings available<br>impletion of cause of |  |
| VILLEI<br>Icien: T   | artificat<br>ctor. p   | BeC              | 25. Was case referre   | ed to medical                    |                           |  |                                   |  | 26. Place of  | 1 Death Check       | Yes 227No                                | 1 Yes   | 2□ No  |  |
| Physic   | this ce<br>al dire   | ို               | 1□Yes 2√N  | 10                               |                           |  | ER/Outpatier                      | 3 DUA                                  |   |                     |  | 6 □Other (Specif                              | (y)  |  |
| ding &   | : Alter<br>s funer   | tlon             | 27. Manner of Death<br>1 Natural<br>2 Accident                           | 5 Pending                        | (Mo                       | e of Injury<br>onth, Day Year)                         | 28b. Time of<br>Injury            | ١ ١                                    | Nork?  Yes 2 No   |                     | scribe how inju                          | iry occurred                                  |  |  |
| r Attending<br>or death.   | rector<br>by the   | ertification:    | 3 Suicide  | 6 Could no determine             | t be 28e. Pla             | ce of Injury - At h                                    | ome, farm, str                    | eet, factory, offi                     | СВ  |                     | ation (Street a                          | nd Number or Rura                             | al Route Number,                                 |  |
| DIVISION OF VICAL To the Hospitel or Attending Physician: within 24 hours after death. | To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2 | O                |  | A Carrie                         |                           |  |                                   |  |   |                     |  |   |  |  |
| e Hos  | e Fun  | edical           | 29a. Certifier<br>(Check only<br>one)                                    | 2 Medical Ex                     | aminer: On the            | ne best of my kni<br>basis of examina<br>anner stated. | owledge, death<br>ation and/or in | n occurred at the<br>vestigation, in m | e time, date and p<br>ly opinion, death o                     | occurred at the     | to the cause(s<br>e time, date an        | s) and manner as s<br>d place, and due to     | stated.<br>the cause(s)                          |  |
| To th  | To th<br>comp  | Me               | 29b. Signature and to  | itle of certifier                | 1,                        |  |                                   | 29c. Lic                               | ense number   | 2                   | 29d. Da                                  | ate signed (Month,                            |  |  |
|  | _  |                  | Xu   | w M                              | JY.                       | <b>り</b>   |                                   | 25                                     | 5745  |                     | Ju                                       | 14 18,  | 2006   |  |
|  | 7  |                  | 30. Nat and address  | ss of perion                     | completed ca              | use of death (Ite                                      | m 23a) (Туре,<br>ЕV)              | endui                                  | le  |                     |  | 150   |  |  |
|  | Sta<br>Registr   |                  | 31. Date filed (Month  | n, Day, Year)                    | 6                         | Registrar's Sign                                       | ature                             |  | -   |                     |  |   |  |  |

06-05041 Valerie Chambers

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death Month Day July 14, 2006 Valerie Chambers **Medical Examiner** 1115 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 410 W. Franklin Street Apt 4 A Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Director Months Davs Hours 218-80-6040 1 M 2 X F 45 08-23-1960 Country) Md. Yrs Usual Residence of Decedent any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Md. NA 1 Yes 2 No 23a or 28a-f show notified at once, and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 410 W. Franklin St. Apt. 4 A 21201 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes Widowed Divorced If Yes, Give Year 1 Yes 2X No specify: Specify: Black Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed than "nat during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) rked other than " ent, the Medical I 21215-0036 12th grade Parks & Recreation City of Baltimore and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) James Chambers Chestina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ant: If item 27 is nor other traumatic Erica Ausby Daughter 610 Lennox Street, Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, timore, 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State Pages 1 Greenmount Cem. 7-19-06 Baltimore, Md. ent Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 1101 E. North Ave. **Physician** Approximate Interval Between Onset and /Medical a. Sharp Force Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last and cal physician a UNPENDED AMENDED Hospital or Attending Physician: The law requires that the death certificate be Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? 2 Dav Pregnant at time of Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 0 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate 1 🗸 Yes ✔ Yes 2 2 No 25. Was case referred to medical 26 Place of Death (Check only one) examiner? Hospital: 1 Other<sub>4</sub> Inpatient 2 this ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes After 28a. Date of Injury FOUND: Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural FOUND: Subject stabbed 5 Pending death. Director: 1 Yes 2 ✔ No Jul 14, 2006 1100 hrs 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) 410 W. Franklin Street Apt. 4 A, Baltimore, Md. determined (Specify) Multi-Family Apt. 4 V Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. within 2 2 Wedical 5/aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title 9 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 15, 2006 30. Name and address of person who completed cause of death (Item 23a) Pamela Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

I Sugario

2006

2. 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** 9:14 AM PAUL SIMON CARTER JUL 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNION MEMORIAL HOSPITAL NA BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months 1**個** M 2□ F Yrs 83 215.12.0586 07.07.1923 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or Itame 23a or 28a-1 show the Medical Examinar must be notified at TOWSON 1 □Yes 2 No **Funeral Director** mo BALTIMORE 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? III WEST ROAD 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 A Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify. Specify: Be Completed by 3 ☐ Widowed 4 ☑ Divorced BUACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd 2 should be filed within 7 slih and Mental Hygiene.
27 le marked other then "r ir treumatic avent, the Men Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE BROKER REAL ESTATE NA 1214 GRADE Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Heelth and Mental Important: If Item 27 Is marked any lightly or other traumatic averages. RAYMOND CARTER ROBERTA PALMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON 209 ATHOLGATE LN., AUEN CARTER BAUTO. MO 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) GARRISON FOREST 07.25.06 OWINGS MIUS MO 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BACTO. NATL PIKE, BACTO. MO 21229 21. Signature of Euneral Service Licensee augh 23a. Part1. Enfecthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner 8 and as Avolte Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examiner attending physicien and for use as the burial-translt Staltes Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. ed by the detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 □ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1√0 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident I Diractor: d in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined eftar 4 | Homicide within 24 hours e To the Funerel C 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 \*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D 3146 2114106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. Entow St Soute 308, BALTIMORE MI) 2/20/ 1 mt12 32 Registrar's Signature 31. Date filed (Month, Day, Near) State Registrar 2 0 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#22, periff, 887, 7/20/06 TI Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1335 PM Month Year **Physician** VIOLA CROCKETT 07 06 18 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS BAYVIEW BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
05 09 1933 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 248.52.9235 1 □ M 2 XF 73 Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. important: if itam 27 is marked other than "natural", or itams 23a or 28a-f ahow any injury or other treumatic event, the Madical Examinet must be notified at once. 10a. State 10b. County 10d. Inside City Limits MD Baltimore 1 SYes 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 618 Avondale Road 21222 . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 KNo Specify: Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Kestaurant ementary/Secondary (0-12) anger Lothgrade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eddie Emma Rice James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Crockett/Daughter ylvia D. 6435 Bushey Street Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, MD Hill 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Compassion Funeral Services
3000 E. Compassion Paltimore Street, Baltimore, MD 21224 21. Signature of Funeral Ser 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS 2 days Physician /Medical Due to (or as a consequence of): Examiner 2 days MRSA BACTEREMUA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. physicien Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 Other (specify) page 2 should be detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Ď Diabetes mellitus Type II 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 2□ No 1 ☐ Yes 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 TYes 2 TNo investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified Kisica Welmin RES-001 07 18 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JESSICA COLBUPN, MD JOHNS HOPHINS BAYVIEW 4940 EASTERN AVE. BALT, NO 21224 31. Date filed (Moght, Pay. 2 ear.) 2006 32. Registrar's Signature State Coortes Registrar

|  |  |                  | . For   | State of M                                  |                                 |                                |   |                     |                  |                 | -                               | giene                        | 0.0           | 22716                           |   |
|--|--|------------------|---|---|---------------------------------|--------------------------------|---|---------------------|------------------|-----------------|---------------------------------|------------------------------|---------------|---------------------------------|---|
|  |  |                  | 1 - State<br>Registrar  |   |                                 | Cei                            | rtificate   | e of L              | Death            |                 |                                 | Reg. No.                     | 00            | 22716                           |   |
| ./A4                                     | Physicia   | an               | 1. Decedent's Name (First, Middle, La<br>Dorothy A. Cop1  |   |                                 |                                |   |                     |                  |                 | 2. Date of De<br>Month          | Day                          | Year          | 3. Time of Death<br>7:00 PMM    |   |
|  | /Medic   | al               | 4a. Facility Name (If not institution, give   |   | -1                              |                                | 4h Cih  | Town or             | Location         | of Dooth        | Dury                            | 13 2<br>4c. Count            | 006           | 7.00 1110                       | _ |
|  | Examin   | er               | Carroll Hospita   |   | ')                              |                                |   |                     |                  |                 |                                 |                              | rol1          |                                 |   |
|  | Funeral  | 200 m            | 5. Social Security Number 6.  | Sex 7. A                                    | Age (In yrs. la                 |                                | ) If Under 1 Year If Under 24 Hrs. 8. Date of Birth |                     |                  |                 |                                 |                              |               |                                 |   |
| В  | Director   |                  | 222-21-42/3   | 1 □ M 2 🛣 F                                 | 41                              | Yrs.                           | Months  | Days                | riours           | 191111.         | Sept I                          | 3, 1964                      | Mar           | yland                           | _ |
|  | and  |                  | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City                       | , Town or Lo                   | cation  | 1                   |                  |                 |                                 |                              | 1             | Od. Inside City Limits          | - |
|  | Maryl<br>-f ehc<br>lind  | tor              | MD Carroll  |   | Mt                              | . Air                          | У   |                     |                  |                 |                                 |                              |               | 1 ☐ Yes 2√ No                   |   |
|  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other than "neturel", or items 23a or 28e-f show servingery or other traumatic event, Its Madical Examinar must be neitlind at ODGe.  | Funeral Director | 10e. Street and Number 4101 Old Nationa   | 1 Pike                                      |                                 |                                | 10f. Zip  | Code<br>1771        |                  |                 |                                 | 10g. Citizen of              | What Cour     | ntry?                           | - |
|  | death  | nera             | 11. Marital Status  | 12. Was Deceder<br>Armed Forces             |                                 | S. 13.                         | Was Deced   | ient ol Hi          | spanic Ori       | gin? (Sp        | ecify Yes or No<br>Rican, etc.) |                              | ce - Americ   |                                 | - |
| 036                                      | ours after<br>ref, or ite<br>Examine   | by               | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced  | 1 Tes 2 No. 1 Yes Cive Year or Dates        | No                              |                                | 1 ☐ Yes   |                     |                  | .,              |                                 |                              | y: whi        |                                 |   |
| 5-0                                      | 72 hc  | Completed        | 15. Decedent's E<br>(Specify only highest gr  | ducation<br>ade completed)                  |                                 | 16a. Dece<br>(Give             | dent's Usua<br>kind of wo<br>DO NOT us              | rk done a           | luring mos       | t of work       | unk<br><sub>Ing</sub>           | 16b. Kind ol E               | Business/In   | dustry                          |   |
| 12                                       | within<br>ene.<br>than   | duic             | Elementary/Secondary (0-12)   | College (1-4o                               | r 5+)                           | me.                            | DO NOT US   | se retired,         | ,                |                 |                                 | data e                       | ntry          |                                 |   |
| 9  | Hygi<br>other  | Be Co            | 17. Father's Name (First, Middle, Las   |   |                                 |                                |   |                     | 18. Mothe        | r's Nam         | e (First, Middle                | , Ma <i>ide</i> n Sumai      | m <i>e)</i>   |                                 | - |
| /lar                                     | uld be<br>Venta<br>Irked   | To B             | Paul Copley   |   |                                 |                                |   |                     | Saı              | ndra            | Canter                          | bury                         |               |                                 | _ |
| Maryland 21215-0036                      | nd 2 sho<br>lith and l<br>27 is ma<br>r trauma   |                  | 19a. Informant's Name/Relationship Sandra Copley/mo   |   |                                 |                                | -   |                     |                  |                 |                                 | er, City or Town<br>rel, MD  |               |                                 |   |
| lore,                                    | ges 1 ar<br>it of Hea<br>if item<br>or other   |                  | 20a. Method of Disposition t □ Burial 2 □ Cremation 3 (   |   | 1 76                            | lace of Dispo<br>emetery, crei | osition (Nari<br>matory or o                        | ne of<br>ther place | 9)               |                 | Date                            | 20c. Location                | - City or To  | own, State                      | - |
| Baltimore,                               | ermit. Pa<br>epartmer<br>nportant<br>ny injury<br>nce.   |                  | 4 ☑ Donation 5 ☐ Other (Special Service Lice Ronald Service Lice Ronald Service Lice Ronald Service Lice Ronald Service Lice Ronald Service Ronald Ronal | 1   | rector                          | St                             | 2. Name an  | d Addres            | s ol Facili      | y<br>oard       | 655 W.                          | Raltim                       | ore 9         | treet                           |   |
|  | ₹0.5 • a   |                  | 23a. Part1. Enter the disease, or constock, or heart lailure. List only   | plications that caus                        | ed the death                    | Ba<br>n. Do not ent            | altimo<br>ter the mod                               | ore,<br>e of dying  | MD<br>g, such as | 2120<br>cardiac | 1<br>or respiratory a           | Baltim                       |               | Approximate<br>Interval Between | 1 |
| S. S. S. S. S. S. S. S. S. S. S. S. S. S | Physician  |                  | Immediate Cause (Final disease or condition   |   | PIRAT                           |                                |   |                     |                  |                 |                                 |                              |               | Onset and Death                 |   |
|  | /Medical<br>Examiner   |                  | resulting in death)   |   |                                 |                                |   |                     |                  |                 |                                 |                              |               |                                 |   |
| 괃  |  | Jer.             | Sequentially list conditions if any, leading to immediate   | U   | UMi<br>as a consequ             |                                |   |                     |                  |                 |                                 |                              |               |                                 |   |
|  | cuted<br>nd<br>transit   | Examiner         | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | c.  |                                 |                                |   |                     |                  |                 |                                 |                              |               |                                 |   |
| 760,                                     | ficate be executed<br>physicien and<br>is the burial-transit   |                  | resulting in death) Last  | Due to (or a                                | as a consequ                    | uence of):                     |   |                     |                  |                 |                                 |                              |               |                                 |   |
| 687                                      | physicate to the table to the table to the table | dicai            |   | d   |                                 |                                |   |                     |                  |                 |                                 |                              |               |                                 | - |
| Box (                                    | death certificate<br>e attending phy<br>d for use as the   | n/Me             | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcom                         |                                 |                                | 75  |                     |                  |                 |                                 | 23d. Da                      | ate of delive | эгу                             |   |
| .O.                                      | 0 0 0  | Physician/Med    | in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 1□Live birth<br>4□Pregnant<br>9□Unknown     | at time of de                   |                                | ∃Ectopic pr<br>∃ Other (sp                          |                     |                  |                 |                                 | М                            | onth          | Day Year                        |   |
| <b>Q</b>                                 | es og  | by               | Part II. Other significant conditions   | contributing to death                       | but not resu                    | ulting in the u                | nderlying c   | ause give           | n in Part I      |                 | 23e. Did                        |                              |               | he cause of death?              |   |
| Vital Records,                           | > 11 0   | leted            |   |   |                                 |                                |   |                     |                  |                 | 24a. Was                        | an 24b.                      | Were auto     | ppsy findings available         |   |
| Re                                       | 0 4 9  | dmo              |   |   |                                 |                                |   |                     |                  |                 | auto<br>perfe                   | ormed?                       | death?        | mpletion of cause of<br>2 □ No  |   |
| ita                                      | sicien: Th<br>certificate<br>rector, pag   | BeC              | 25. Was case referred to medical examiner?  |   | /                               |                                |   |                     |                  | of Deat         | h Check only                    | one)                         |               |                                 |   |
| of\                                      | Phys<br>this<br>al di  | . To             | 1 Yes 2 No  | Hospital: 1 1 pa                            |                                 | ER/Outpaties                   |   | Othe<br>18c. Injury | 4 🗆 190          | irsing Ho       |                                 | dence 6 Ot                   |               | (y)                             |   |
|  | ing<br>After<br>une  | tion             | 1 Natural 5 Pending 2 Accident investigate  | (Month, I                                   | Day Year)                       | Injury                         | M   | Work                | (?<br>Yes 2 □    | No              | 200. Describe                   | now injury occu              | 1160          |                                 |   |
| Division                                 | i or Attending<br>effer death.<br>Director: After<br>d in by the fune  | Certification:   | 3 Suicide 6 Could not determine   | 28e. Place of                               | Injury - At ho<br>etc. (Specify |                                | reet, factory                                       | , office            |                  |                 |                                 | Street and Num<br>wn, State) | ber or Rura   | al Route Number,                | - |
|  | urs<br>urs<br>ille   |                  | (Check only 2 Medical Exa   | hysician: To the ba<br>iminer: On the basis | of examinat                     | tion and/or in                 | vestination   | in my or            | ninion dea       | th occur        | red at the time.                | date and place               | and due to    | o the cause(s)                  | - |
|  | To the Hosp within 24 ho To the Functional Completely f  | Medical          | one) 29b. Signature and title of certifier  | and manner                                  | stated.                         |                                | 290   | c. License          | number           |                 |                                 | 29d. Date signe              | ed (Month,    | Day, Year)                      |   |
|  | ⊢≯⊢ŏ   |                  | · A.J.  | Heloy                                       | M.                              | <b>A</b> .                     | 1   | Do                  | 017              | 69              | 75                              | July                         | 14,           | Day, Year) 2006 1/NSTER         |   |
|  |  |                  | ABDAIIAH J. HE  | LOU M.                                      | death (Item                     | CAR                            | Print) ROLL   | - 17                | tospi            | TAL             | CENT                            | ER WE                        | SIM           | INSTER                          |   |
|  | Sta<br>Regist  |                  | 31. Date liled (Month, Day, Year)  JUL 2 0 200  | 32. Regi                                    | strar's Signa                   | ture                           |   |                     |                  |                 |                                 | /*                           | <i>U</i>      |                                 |   |

Amend item#27, peristre of Waryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** DOUGLAS O'DELL CHAPMAN June 9, 2006 9:45 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home St. Mary's Charlotte Hall 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠M 2□F 400-24-8505 82 Director 13, 1923 West Virginia Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 27 is marked other then "natural", or iteme 23a or 28a-f ehow treumatic event, the Medical Examinar must be notified at 1₺Yes 2□No Directo Maryland Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11220 Odell Farms Court 20705 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or them any Injury or other treumatic event, the Mantines expense. Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WWII Completed by Year or Dates: 3 XWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry C.W. Dent Elementary/Secondary (0-12) College (1-4or 5+) Carpet Installer Carpet Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elsie Miller Otis Guy Chapman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna S. Manahan - Daughter 11220 Odell Farms Ct., Beltsville, MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 6/16/2006 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Jervice Line see 4739 Baltimore Avenue, Hyattsville, MD 20781 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced Colon Cancer with Metastasis /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ending physicien and use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Diabetes Mellitus Type I Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Anemia IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Left Hip Fracture 1 Tes 2 No 3 Probably 4 ☑Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No Hypertension certificate : After this certifical funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4™ Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 1 X Yes 2 □ No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury DI. fell @VA + Chatarat 5 Pending bathroom To the Hospital or Attention, within 24 hours after death.

To the Funeral Director; After managed in by the further and the f 31/06 Fall 1 ☐ Yes 2 No investigation 2 X Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide VAMC

| Washing ton Dic

| IN Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| In the past of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| In the past of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 6/26/2006 anno D45092 completed cause of death (Item 23a) (Type, Print) 12+1 30. Name and address of person tho. 110 Hospital Suite #205, Prince Frederick, Maryland 20678 Road, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2 0 2006 Constell ! Registrar

|                |   |                | For<br>State<br>Registrar   |   | State of M  | /larylan                 |                        | artment<br>rtificate           |                   |                        | and M                   |   |                          | 106                          | 22718   |
|----------------|---|----------------|---|---|---|--------------------------|------------------------|--------------------------------|-------------------|------------------------|-------------------------|---|--------------------------|------------------------------|---|
|                |   |                | Registrar  1. Decedent's Name (First,   | Middle Last)                                |   |                          | <i></i>                | runcate                        | OIL               | Jeani                  | T                       | 2. Date of De                           | Reg. No.                 |                              | 3. Time of Death                              |
|                | Physici   |                | Charles   | .mooie, Easty                               | Co  | Ilins                    |                        |                                |                   |                        |                         | Month                                   | Day                      | 2006                         | 3:11 PM                                       |
|                | /Medio<br>Examin  |                | 4a. Facility Name (If not ins   | titution, give s                            |   |                          |                        | 4b. City, To                   | own, or l         | Location o             | f Death                 | July                                    |                          | nty of Death                 |   |
|                | Exami   |                | Northwes  | + Ho  | spital  | Cent                     | er                     | Ro                             | and               | alls                   | tow                     | n                                       |                          | Baltin                       | nore  |
|                | Funeral<br>Director   | Ğ.             | 5. Social Security Number 214-26-7667   | 6. Sex                                      |   | Age (In yrs. I           | ast birthday)<br>Yrs.  | If Under 1<br>Months           | Year<br>Days      | If Under 2<br>Hours    | Min.                    | 8. Date of Birt<br>(Month, Da<br>Dec 23 | h<br>y, Year)<br>3, 1927 |                              | place (State or Foreign<br>intry)<br>Maryland |
|                | D >   |                | Usual Residence of Decede   |   |   | 10c Cin                  | , Town or Lo           | neation                        |                   |                        |                         |   |                          |                              | 10d. Inside City Limits                       |
|                | e Maryla<br>e-f ehov  | ctor           | Maryland  | N/A   | 4   | 100.00                   | , TOWN OF EC           | Cation                         | Bal               | ltimore                |                         |   |                          |                              | 1 Yes 2 No                                    |
|                | 3e or 28  | I Director     | 10e. Street and Number<br>4613 Pen Lucy I   | Road  |   |                          |                        | 10f. Zip C                     | Code              | 2122                   | 9                       |   | 10g. Citizen             | of What Cou<br>U.S.A         | ,   |
| 36             | 72 hours after deeth with the Maryland<br>Insturet; or Itema 23e or 28e-f ehow<br>Jose Exacultier mast be notified at   | by Funeral     | 11. Marital Status  1 Never Married 20 3 Widowed 4 Div  | Married                                     | 12. Was Deceder<br>Armed Force:<br>1 ☑ Yes 2 ☐<br>If Yes, Give<br>Year or Dates | s?<br>∃ No               |                        | Was Decede                     |                   | spanic Origin, Mexican | gin? (Spe<br>, Puerto F | cify Yes or No<br>Rican, etc.)          | E                        | Race - Ameri<br>Black, White |   |
| ğ              | n 72 hou<br>n "nature<br>leuice E   |                |   | cedent's Educ                               |   |                          | 16a. Dece              | dent's Usual<br>kind of work   | Occupa            | tion                   | a f work in             |   | 16b. Kind o              | f Business/Ir                | ndustry                                       |
| 121            | within ene.   | Completed      | Elementary/Secondary (0   | highest grade<br>)-12)                      | College (1-4o   | r 5+)                    | life.                  | DO NOT use                     | retired)          | Driver                 |                         | g                                       |                          | Self Em                      | ployed  |
|                | be filed<br>stal Hyg<br>od othe<br>event,   | Be             | 17. Father's Name (First, N   | liddle, Last)<br>Samuel                     | Collins   |                          |                        |                                |                   | 18. Mothe              | r's Name                | (First, Middle, Vio                     | Maiden Sum<br>la Jacks   |                              |   |
| <u></u>        | and and   | ို             | 19a. Informant's Name/Re<br>Dorothy Collins   |   | оө, Print)  |                          |                        |                                |                   |                        |                         | Route Numbere, Marylar                  |                          |                              | p Code)                                       |
|                | Heel<br>Heel<br>Fm 2<br>ther  | 18             | 20a. Method of Disposition  |   |   |                          | lace of Dispo          | osition (Name                  | e of              | 1                      |                         | ate                                     |                          | on - City or T               | own, State                                    |
|                | Pege<br>nent c<br>ant: if   |                | 1 ☑ Burial 2 ☐ Crem<br>4 ☐ Donation 5 ☐ Of  |   | emoval from Star  | te                       | •                      | Zion Ce                        | ·                 | 1                      | 0                       | 7/21/06                                 | Lan                      | sdowne,                      | Maryland                                      |
| Balt           | permit. Peg<br>Department<br>Important: I<br>any injury o   |                | 21. Signature of Funeral S  | ervice License                              | 1 5   | 3/0                      | 2                      | 2. Name and<br>Este<br>130     |                   |                        |                         | l Service,<br>imore, Mo                 | P. A.<br>121217          |                              |   |
|                |   |                | 23a. Part1. Enter the disease shock, or heart failure   | ise, or compli                              | cations that caus   | ed the death             | Do not en              |                                |                   |                        |                         |   |                          |                              | Approximate<br>Interval Between               |
|                | Physician<br>/Medical   |                | Immediate Cause (Final disease or condition resulting in death)   | _ a   | Multip  |                          |                        | ysten                          | n fo              | allur                  | e                       |   |                          |                              | Onset and Death                               |
| Н              | Examiner  |                | Sequentially list conditions  |   | System  | nic II                   | ofter                  | mato                           | ry                | resp                   | onse                    | synd                                    | rome                     |                              |   |
| 1              | nted<br>Insit   | Examiner       | Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury | ·₹  | Dub to (or a  | as a consequ             | ,                      | eumo                           | nia               | 1                      |                         | 1                                       |                          |                              |   |
| ,092           | ate be executed sysicien and he burial-transit  | Exa            | that initiated events<br>resulting in death) Last   | l °   | Due to (or a  | as a consequ             |                        | COMPTO                         | 17,0              |                        |                         |   |                          |                              |   |
|                | physic<br>the b   | dical          |   |   | l   |                          |                        | ·                              |                   |                        |                         |   |                          |                              |   |
| P.O. Box 6     | The faw requires that the death certificat are seen signed by the attending phypage 2 should be detached for use as the | Physician/Med  | IF FEMALE: 23b. Was decedent pregning in the past 12 months 1 yes 2 No 9 Unknown                          | ant   | 3c. If yes, outcon<br>1 □Live birth<br>4 □ Pregnant<br>9 □ Unknown              | 2 Fetal<br>at time of de | Ideath 3[              | ⊒Ectopic pred<br>□ Other (spec |                   | -                      |                         |   |                          | Date of deliv<br>Month       | rery<br>Day Year                              |
| S,<br>O,       | es thet<br>igned by<br>be deta  | by Ph          | Part II. Other significant o  | 1 1   | . 1   |                          | ulting in the u        | Inderlying cal                 | use give          | n in Part I.           |                         | 23e. Did to                             | obacco use c             |                              | the cause of death?                           |
| ord            | w require<br>been si<br>should b  | eted           | Gastrointest  | inal I                                      | nemorrh   | lage                     | Adı                    | rit mo                         | aras              | mus.                   | _                       | i                                       | /es 2□No                 | 300000                       | bably 4 Unknown                               |
| Vital Fecords, | The faw<br>seteras t<br>page 2 s  | Completed      | Metastatic  | eles m                                      | ate can   | cerl                     | 1                      | ovasec<br>iia, chi             | ,                 | c dis                  | <u>ea</u> se            | 24a. Was<br>autop<br>perfo<br>1 Yes     | rmed?                    | prior to condeath?           | opsy findings available ompletion of cause of |
| Vita           | ician: Th<br>certificete<br>rector, pag   | Be             | 25. Was case referred to rearminer?   |   | Ionaital: /   |                          |                        |                                | Othe              |                        |                         | (Check only o                           |                          |                              |   |
| o              | ng Phys<br>fter this<br>ineral di   | on: To         | 1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐  | Pending                                     | 28a. Date of li<br>(Month, I  |                          | 28b. Time of<br>Injury |                                | c. Injury<br>Work | at :?                  | 2                       | ne 5 Resident                           |                          |                              | (fy)  |
| Division       | To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu       | Certification: | L _ Nocidon   | investigation<br>Could not be<br>determined | 28e. Place of building,   | Injury - At ho           | ome, farm, st          | M reet, factory,               |                   | /es 2 □ I              |                         | 8f. Location (S<br>City or Tox          |                          | ımber or Rur                 | al Route Number,                              |
| ٥              | pitat o   |                | 29a. Certifier 117 C  | ertifying Phys                              | sician: To the be   | at of my kn              | władne diaz            | th concurred a                 | t tha tim         | date an                | d Strina a              | nd due to the                           | causids) and             | manner as                    | stater!                                       |
|                | To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the              | Medical        | (Check only 2 M<br>one)   | edical Exami                                | ner: On the basis<br>and manner   | s of examina             | tion and/or in         | ivestigation, i                | in my op          | oinion, dea            | th occurre              | d at the time,                          | date and plac            | e, and due                   | to the cause(s)                               |
| 10             | To  | Σ              | 29b. Signature and title of   | certifier A.A.                              | n   |                          |                        |                                |                   | number<br>462          |                         |   | 29d. Date sig<br>July    |                              |   |
| (              | $\mathcal{D}_{\mathcal{A}}$   | 8              | 30. Name and address of   | JAN 141                                     | moleted cause of  | of death (Item           | 23a) /Tuna             |                                |                   |                        |                         |   |                          |                              |   |
|                | 3   |                | J Bos   | ton   | Nort  | hwes                     | st H                   | ospite                         | 1 (               | Cente                  | 25                      | Randal                                  | Istowr                   | , Mar                        | yland 21133                                   |
|                | St<br>Regist  | ate<br>rar     | 31. Date filed (Month, Day  |   | 2. Regi   | strar's Signa            | ture                   | the state of                   |                   |                        |                         |   |                          |                              | •   |

|                   |  | •              | _ For   | epartment of Health and N<br>Certificate of Death                                   |                                    | ne 2006                                      | 22719  |
|-------------------|--|----------------|---|---|------------------------------------|--|--|
| H                 | Physicia   | _              | Decedent's Name (First, Middle, Last)   |   | 2. Date of Death<br>Month<br>July  | Day Year                                     | 3. Time of Death                                   |
|                   | /Medic   | al             | George L. Christopl  4a. Facility Name (If not institution, give street and number)   | 161 4b. City, Town, or Location of Death  | July                               | 13 2006<br>4c. County of Dea                 |  |
|                   | Examin   | er             | 16 Thomas Lane  | Sparrows Point  |                                    | Baltimo:                                     | re   |
|                   | Funeral  |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birt.   | hday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.                      | 8. Date of Birth<br>(Month, Day, Y | 9. Bir                                       | thplace (State or Foreign                          |
|                   | Director   |                | 219 20 1341 12  | frs. World's Days 110015  | May 6, 1                           | 934 Ma                                       | ryland   |
|                   | pu x   |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town   | or Location   |                                    |  | 10d. Inside City Limits                            |
|                   | daryis   | 5              |   | ows Point   |                                    |  | 1 ☐ Yes 2 🛣 No                                     |
|                   | the the  | Directo        | 10e. Street and Number  | 10f. Zip Code   | 10g                                | . Citizen of What Co                         | ountry?  |
|                   | 3a of  |                | 16 Thomas Lane  | 21219   |                                    | U.S.   |  |
| 21215-0036        | should be filed within 72 hours after death with the Maryland od Mental Hygjene. It marked other then "natural", or iteme 23a or 28a-f show it marked other then "natural", or iteme 23a or 28a-f show umatic event, the Modical Exercities routh to notified at | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 \( \) Midowed 4 \( \) Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 \( \) Yes 2 \( \) No. If Yes, Give Year or Dates:    | 13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto      | ecify Yes or No-<br>Rican, etc.)   | 14. Race - Ame<br>Black, Whit<br>Specify: Wh |  |
| ģ                 | 72 ho  | Be Completed   | 15. Decedent's Education 16a. (Specify only highest grade completed)  | Decedent's Usual Occupation (Give kind of work done during most of work             | ting 16                            | b. Kind of Business                          | /Industry  |
| 7                 | ithin  | de la          | Elementary/Secondary (0·12) College (1-4or 5+)  | (Give kind of work done during most of work life. DO NOT use retired)  Truck Driver |                                    | Transp                                       | ort  |
| 2                 | filed w<br>Hygier<br>other th  | ខ្ញ            | 17. Father's Name (First, Middle, Last)   |   | e (First, Middle, Ma               |  |  |
| Maryland          | Mental H<br>Mental H<br>arked ot<br>atic ever  | Be             | George E. Christopher   |   | a M. Hyne                          |  |  |
| 2                 | should be<br>nd Menta<br>marked<br>imatic ev   | ဥ              |   | Mailing Address (Street and Number or Rui   |                                    |  | Zip Code)  |
| Σ                 | nd 2 s<br>lith ar<br>27 is<br>r trau   |                | Darlene Buniff / Daughter 16  | Thomas Lane Sparr   | ows Point                          | , Marylan                                    | d 21219  |
| altimore,         | permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic events.   |                |   | Disposition (Name of y, crematory of other place)  Aven Mem. Park 7/18              |                                    | c. Location - City or<br>1en Burni           | Town, State<br>e, Maryland                         |
| Balt              | permit. Departr Importa eny inju   |                | 21. Signature of Funeral Fervice Licensee   | 22. Name and Address of Facility G. 4001 Ritchie Highwa                             |                                    |  |  |
| ł.                | Physician  |                | 23a. Part 1. Enter the disease or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition | not enter the mode of dying, such as cardiac at the first transfer of the land      |                                    | t,   | Approximate<br>Interval Between<br>Onset and Death |
|                   | /Medical<br>Examiner   |                | Due to (or as a consequence of  | of):  | jung                               |  | 7500   |
|                   | outed id   | Examiner       | Sequentially list conditions, if any, leading to in mediate cause. Enter thing to cause (Disease or injury that initiated events  | Л).   |                                    |  |  |
| 38760,            | ficete be executed<br>physicien and<br>is the burial-transit   | dical Ex       | resulting in death) Last  Due to (or as a consequence of d.   | of):  |                                    |  |  |
| ~                 | ntifice<br>ng ph   |                | IF FEMALE:  |   |                                    |  |  |
| .O. Box           | The law requires that the death certificate has been signed by the attending I page 2 should be detached for use as  | Physician/M    | 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown   | 3 Ectopic pregnancy 5 Other (specify)   | -                                  | 23d. Date of de<br>Month                     | livery<br>Day Year                                 |
| <u>α</u>          | juires that<br>n signed by   | þ              | Part II. Other significant conditions contributing to death but not resulting in  | the underlying cause given in Part I.   |                                    |  | o the cause of death?                              |
| Records,          | The law requirente has been single 2 should b  | Completed      | // //   |   | 24a. Was an autopsy performe       | d? prior to death?                           | utopsy findings available completion of cause of   |
| ita               | ilan:<br>ortifica<br>stor, f   | BeC            | 25. Was case referred to medical examiner?  |   | th (Check only one)                |  |  |
| <u>~</u>          | hysic<br>his ce<br>I dire  | 은              | 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou  |   |                                    | ce 6 ☐Other (Spe                             | ocify)   |
| פֿח               | Attending Physician: or death. ector: After this certifics by the funeral director, I  | ino<br>in      | 1 atural 5 □ Pending (Month, Day Year) II   | Fime of 28c. Injury at Work?  | 28d. Describe how                  | injury occurred                              | 0  |
| sio               | tendi<br>teath.<br>tor: A  | cat            | 2 Accident investigation 3 Suicide 6 Could not be 380 Blace of Injury At home fa  | M 1 Yes 2 No  | 29f Location (Stre                 | et and Number or R                           | um l Pouto Number                                  |
| Division of Vital | et or Attend<br>s after death<br>if Director:  | Certification: | 3 Suicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)  | mi, street, factory, office   | City or Town,                      |  | urar riodie rediciber,                             |
|                   | To the Hospitel or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2   | edical         | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.                          |   | red at the time, date              | and place, and du                            | e to the cause(s)                                  |
|                   | To the comp  | Ž              | 29b. Signature and title of certifier   | 29c. License number   | 290                                | Date signed (Moni                            | th, Day, Year)                                     |
| ~                 | 117  |                | 30. Name and address of person who completed cause of death (Item 23a)  | (Type, Print)   |                                    | my 19  | , 0006   |
| 1                 | / <u>'</u>   |                | Alant. Dounis un 901 E  | ger Port Aue,   | Bull                               | , no   | 21230  |
|                   | Sta<br>Regista   |                | 31. Date liled (Month, Day, Year)  32 degistrar's Signature   | Type, Print)  4 of Port Au,  Specific   |                                    |  |  |

|                                |  |                | For State Registrer   | State of                             | Marylan                           | d / Depa<br><i>Cei</i> | artment o                                | of Hea                   | alth a                         |                            |                            | Rag. No.     | 2006  | 227   | 20       |
|--------------------------------|--|----------------|---|--------------------------------------|-----------------------------------|------------------------|--|--------------------------|--------------------------------|----------------------------|----------------------------|--------------|---|---|----------|
|                                | Physicia   | an             | 1. Decedent's Name (First, Middle, Las  |                                      |                                   | -                      |  |                          |                                | 2                          | Date of De.<br>Month       | Day          | Year  | 3. Time of I                                |          |
|                                | /Medic   | al             | Eddiebelle Lo  4a. Facility Name (If not institution, give  |                                      |                                   | : L                    | 4b. City, To                             | wn orlo                  | ocation of                     | Death                      | July                       |              | 2006<br>County of Death                           | 3:30  | Ам       |
|                                | Examin   | er             | Manor Care-Bethes   |                                      | iber)                             |                        |  | thes                     |                                | Death                      |                            |              | ontgome   |   |          |
|                                | Funeral  |                | Social Security Number 6. S | x                                    | 7. Age (In yrs. I                 |                        | If Under 1 \                             | rear If                  | f Under 2                      | 4 Hrs. 8                   | Date of Birt               | h            | 9. Birth  | place (State or                             | Foreign  |
|                                | Director   |                | 223-03-2033   | ⊒M 23€ F                             | 88                                | Yrs.                   | Months C                                 | ays I                    | Hours                          | J.                         | uly 27                     | <b>,</b> 191 | 7 Wash  | ington,                                     | D.C.     |
|                                | pug *  | -              | Usual Residence of Decedent  10a. State 10b. County   |                                      | 10c. City                         | , Town or Lo           | cation                                   |                          |                                |                            |                            |              |   | 10d. Inside City                            | y Limits |
|                                | Maryla<br>f sho  | 0              | Maryland Montgom  | erv                                  |                                   | Bet                    | thesda                                   |                          |                                |                            |                            |              |   | 1 🗌 Yes                                     | 2 🔯 No   |
|                                | r 28e-   | Directo        | 10e. Street and Number  |                                      |                                   |                        | 10f. Zip Co                              | ode                      |                                |                            |                            | 10g. Citize  | en of What Cou                                    | ntry?                                       |          |
|                                | th with  | alD            | 5419 Audubon Road   |                                      |                                   |                        |  | 2                        | 20814                          | 4                          |                            | Uni          | ted Sta   | tes   |          |
|                                | eme.   | Funeral        | 11. Marital Status  | 12. Was Dece<br>Armed For            | dent Ever in U.                   | S. 13.1                | Was Deceden<br>f Yes, specify            | t of Hispa<br>Cuban, I   | anıc Origi<br>Mexican,         | in? (Specifi<br>Puerto Ric | y Yes or No<br>can, etc.)  | - 1          | <ol> <li>Race - Ameri<br/>Black, White</li> </ol> |   |          |
| 30                             | s afte   | by Fu          | 1 Never Married 2 Married :<br>3 Widowed 4 Divorced   | 1 ☐ Yes<br>If Yes, Giv<br>Year or Da | 2 No                              |                        | 1 ☐ Yes 2🕱                               | No S                     | Specity:                       |                            |                            | 3            | Specify: Wh:                                      | ite   |          |
| 3                              | filed within 72 hours after death with the Maryland<br>Hygiene.<br>the than "natural", or Iteme 23s or 28e-f show<br>ent, the Medical Examiner must be codified at   | edt            | 15. Decedent's Ed   | ucation                              | 103.                              | 16a. Deced             | dent's Usual C                           | Occupatio                | on                             |                            |                            | 16b. Kin     | d of Business/Ir                                  | ndustry                                     |          |
| 212<br>2                       | hin 72<br>sn "na<br>Medis  | plet           | (Specify only highest grade Elementary/Secondary (0-12)   | de completed) College (1             | -4or 5+)                          | (Give<br>life. l       | kind of work of<br>DO NOT use i          | done duri<br>retired)    | ing most                       | of working                 |                            |              | gomery  |   |          |
| 7                              | giene<br>giene<br>er the   | Be Completed   |   | 2                                    |                                   | Seci                   | cetary                                   |                          |                                |                            |                            |              | ic Scho   | ols   |          |
|                                | be fill<br>d oth   | Be             | 17. Father's Name (First, Middle, Last) William Russell L   | owerv                                |                                   |                        |  | 18                       |                                | ,                          | First, Middle,<br>e Perr   |              | iumame)   |   |          |
| <u>2</u>                       | hould<br>d Mer<br>marke  | 2              | 19a. Informant's Name/Relationship (7   |                                      |                                   | 19b Mailir             | na Address (S                            | treet and                |                                |                            |                            |              | Town, State, Zi                                   | p Code)                                     |          |
| Sa                             | od 2 s<br>Ith an<br>27 is r  |                | Charles L. Carmich  |                                      |                                   |                        |  |                          |                                |                            |                            |              | nd 2103   |   |          |
| ē,                             | es 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiens of Health and Mental Hygiens 4 filem 27 is marked other then "natural", or tleme 23a or 28e-f show if them 27 is marked other then "natural", or theme 23a or 28e-f show if other traumatic event, the Medical Examinar must be notified at |                | 20a. Method of Disposition  |                                      | 20b. P                            | lace of Dispo          | sition (Name<br>matory or othe<br>Heaven | of<br>er place)          | Ta                             | ıly 2                      |                            | 20c. Loc     | ation - City or T                                 | own, State                                  |          |
| Ē                              | Pages<br>nent of<br>ant: if it<br>ary or o   |                | 1 ☑ Burial 2 ☐ Cremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Specify   |                                      | State Gat<br>Ce                   | metery                 | 7  |                          | 20                             | 006                        |                            |              | er Sprin  |   |          |
| Baltimore, Maryland 21215-0036 | permit. Page<br>Department of<br>important: if<br>eny injury or  |                | 21. Signature of Funeral Service Licen  | see                                  | M001                              | .98 R                  | Name and A<br>bert A<br>57 Wisc          | Address of<br>Pi<br>ons: | of Facility<br>Imphi<br>In Ave | rey Fre. Be                | uneral                     | Home         | e/ <sup>Bethe</sup><br>Cha<br>20814-              | sda-Che<br>se, Inc<br>-3501                 | vy       |
| . 3                            |  |                | 23a. Part1. Enter the disease, or composhock, or heart failure. List only   | olications that cone cause on e      | aused the deatl<br>ach line.      | n. Do not ent          | er the mode o                            | of dying, s              | such as c                      | ardiac or r                | espiratory a               | rrest,       |   | Approximate<br>Interval Betw<br>Onset and D | reen     |
| j                              | Physician  |                | Immediate Cause (Final disease or condition resulting in death)   | a                                    | eft Cer                           |                        | scular                                   | Acc                      | iden                           | t w/r                      | ight                       | Hemip        | legia   | Onset and D                                 | Dati i   |
|                                | /Medical<br>Examiner   |                | resulting in deathy   |                                      | orasa consequin's Ly              |                        |  |                          |                                |                            |                            |              |   |   |          |
|                                |  | ē              | Sequentially list conditions, if any, leading to immediate  | h                                    | or as a consequ                   | -                      |  |                          |                                |                            |                            |              |   |   |          |
|                                | uted<br>id<br>ansit  | Examiner       | Cause (Disease or injury that initiated events  | Hyper                                | tension                           |                        |  |                          |                                |                            |                            |              |   |   |          |
| Ö,                             | e exec<br>ien ar<br>urial-tı   | Exe            | resulting in death) Last  |                                      | oras a consequ<br>1 Fibri         | ,                      | n  |                          |                                |                            |                            |              |   |   |          |
| 8760,                          | icate be executed<br>physicien and<br>s the burial-transit   | dicai          | •   | d                                    | I FIDIT                           | TIACIO                 |  |                          |                                |                            |                            |              |   |   |          |
| 9 X                            | leath certifica<br>attending ph<br>I for use as th   | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, out                     | come of pregna                    |                        |  |                          |                                |                            |                            | 23           | 3d. Date of deliv                                 | erv   |          |
| Вох                            | death<br>e atter<br>d for u  | iciar          | in the past 12 months?  | 4□Pregn                              | irth 2 ☐ Feta<br>ant at time of d |                        | Ectopic preg<br>Other (speci             |                          |                                |                            |                            |              | Month   | -   | ear      |
| P.O.                           | that the de<br>ed by the<br>detached   | hys            | 9 Unknown   | 9□ Unkno                             | own                               |                        |  |                          |                                |                            |                            |              |   |   |          |
|                                | 8 G 9  | by             | Part II. Other significant conditions of  | ontributing to de                    | eath but not res                  | ulting in the u        | nderlying caus                           | se given i               | in Part I.                     |                            |                            |              | e contribute to<br>No 3□Pro                       |   |          |
| 0.0                            | w requir<br>been si<br>should  | eted           |   |                                      |                                   |                        |  |                          |                                |                            |                            |              |   |   |          |
| Rec                            | has t  | Completed      |   |                                      |                                   |                        |  |                          |                                |                            | 24a. Was<br>autor<br>perfo |              | death?  | ompletion of ca                             |          |
| <u></u>                        |  | e Co           | 25. Was case referred to medical  |                                      |                                   |                        |  | 2                        | 6 Diace                        | of Death /                 | 1 ☐ Yes<br>Check only o    |              | 1 🗆 Yes   | 2□ No                                       |          |
| >                              | nysician:<br>ns certifica<br>director, p   | To B           | examiner?<br>1 ☐ Yes 2 🎛 No   | Hospital: 1 🔲 I                      | npatient 2                        | ER/Outpatier           | nt 3 DOA                                 | 0.4                      |                                |                            |                            |              | ☐Other (Speci                                     | fy)   |          |
| 0                              | Attending Physician: ir death. ector: After this certifics by the funeral director, I  | L :uc          | 27. Manner of Death 1 XNatural 5 □ Pending  | 28a. Date (Moni                      | of Injury<br>th, Day Year)        | 28b. Time o            | f 28c                                    | . Injury at<br>Work?     |                                |                            | d. Describe                |              |   |   |          |
| Sio                            | eath.<br>or: Af<br>the fu  | catic          | 2 Accident investigation  |                                      |                                   |                        | М  |                          | s 2 🗆 N                        |                            |                            |              |   |   |          |
| Division of Vital Records,     | i die  | Certification: | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined   | 286. Place                           | of Injury - At hong, etc. (Specif | ome, farm, str<br>y)   | reet, factory, c                         | office                   |                                | 28                         | City or To                 |              | Number or Rui                                     | al Route Numb                               | ier,     |
|                                | Hospite<br>4 hours<br>Funarel  | edical C       | 29a. Certifier 1 Cartifying Ph<br>(Check only one)  | niner: On the ba                     |                                   |                        |  |                          |                                |                            |                            |              |   |   |          |
|                                | To the within 2 To the complet   | ₹              | 29b. Signature and title of certifier   | 1/                                   | 0                                 | 1 1                    | 29c. L                                   | icense n                 | number                         |                            |                            | 29d. Date    | signed (Month                                     | Day, Year)                                  |          |
|                                | ~  |                | 1 Cuti  | V                                    | Thra                              | M                      | -1)                                      | D202                     | 274                            |                            |                            | July         | 7 18, 20  | 006   |          |
|                                | 0  |                | 30. Name and address of person who Kirti Vohra, M.D.  | 7710                                 | Bradley                           | Blvd.                  | , Beth                                   | esda                     | ı, Ma                          | ırylar                     | nd 20                      | 817          |   |   |          |
| 1000000                        | Sta<br>Regist  |                | 31. Date filed (Month, Day, Year)  JUL 2 0 2  | 006 <sup>32. 8</sup>                 | gistrar's Signa                   | ture<br>J.             | barle                                    |                          |                                |                            |                            |              |   |   |          |

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** 5:45 07 07 2006 4b. City, Town, or Location of Death Elizabeth /Medical Jane 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** RALTIMORE HOSPITA ( 600D SAYAKITAN If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 8. **Funeral** 1 M 1 X Hours Months Days 79 07 Director 10 26 159-22-4976 Usuaf Residence of Deceden PA with the Maryland 10d. fnside City Limits 10c. City. Town or Location 10b County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Musical Experiment must be notified at ORE. 1√Yes 2 No Director MD NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5212 Downing Road U.S.A. 21212 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2☐No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced Black Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Morgan State Elementary/Secondary (0-12) College (1-4or 5+) 12th grade University Associate Professor 8yrs+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William F. Enty Lillian Storgle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If Item 27 is Carolyn French-Cousin P.O. Box 132, Barboursville, VA 22923 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/17/06 Woodlawn Baltimore Co, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOGENI Physician SHOCK /Medical Due to (or as a consequence of) Examiner IN FARCTION MYOCARDIAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physician and for use as the burial-transit CORONARY Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 DNo 24a. Was an autopsy performed 1 🗌 Yes 2 No To the Hospital or Attanding Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Yes 2€No 2 ER/Outpatient 3 DOA this After thi 28b. Time of Injury Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 ☐ Suxcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours after To the Funeral Dire 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medica (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) ABOVGERGI M.D RES 000 to the same of the 30. Name and advess of person who completed cause of death (frem 23a) (Type, Print) NARWAN ABOUGERGE, 600D SAMARITI 5601 LOCH RAVEN BLUD 600D SAMARITAN HOSPITAL MD 21239 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2006 State Registrar

TANG ON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 6:15 PM 100 July 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number), Bulto Examiner Ulemoria 60 5. Social Security Number 217 - 94 - 7324 In yrs. ast birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 6. Sex **Funeral** (State or Foreign Days Hours Min 1□M 25 F 7 Yrs Director Usual Residence of Decedent death with the Maryland r 28a-f show 10a State 10c. City, Town or Location 10d. Inside City Limits 10b Counts 1 Tes 2 No Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? other than "natural", or items 23s or vent, the Mudical Examiner must be 45 3800 zrn da 2120 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after in nent of Heelth and Mental Hygiene. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House keeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider Be lemencia ۵ 19b. Mailing Address (Street and Number or Rural Rouls Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) mother 3800 Firnd to 21207 lemencia Important: if itsm sny injury or other 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Greenmount crematory 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Balko 4 ☐ Donation 5 ☐ Other (Specify) 24 2000 22. Name and Address of Facility 21. Signature of Funeral Service License uneral Service 170 Mc Culloh 1217 23a. Part1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiralory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsevand Death Immediate Cause (Final disease or condition resulting in death) Intracvaniableed Physician hours /Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate hes page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No 212 No 1 ☐ Yes Fo the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ၉ 1 Dinpatient 2 ER/Outpatient 3 DOA this To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) July 18, 200 AU4176435D12706C rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Memorial Hospital, MD Desai Union Nidhi 31. Date filed (Month, Day, Year) 32. egistrar's Signature

State

Registrar

JUL 2 0 2006

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Eleam Year Physician 945 AM William Juh 2006 /Medical 4c. County of Death Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hospital Howard County General Columbia Howard If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 🔀 M 2 🗆 F 07/03/1952 050-44-4145 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or itema 23a or 28e-f ahow the Medical Exampler must be notified at 1 Yes 2 No **Funeral Directo** MD Baltimore indsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 luffdale death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk 11th Grade NA Hospita it of Health and Mental Hygis if Itam 27 is marked other or other traumatic avant, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked oth any jury or other traumatic avant pose. 18. Mother's Name (First, Middle, Maiden Sumame) William W. homas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5742 Thurder Hill Rd Columbia MD 21045 <u>Elean</u> (wife Debra 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmount 7/21/2006 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral SVC. Vaugh C Greene Funeral SVC. 5757 Balto Nutt P. Ke, Baltimope, MD, 21229 Funeral Svc. 21. Signature of Funeral Service Licensee Vaudrn Greene 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hepato cellular Immediate Cause (Final disease or condition resulting in death) two months carcinoma **Physician** /Medical Due to (or as a consequence of) Hepatitis Examiner unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of) Examine Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cirrhosis 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No this certificate 1 ☐ Yes 🔊 No 1 Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 X No After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Accident Division 5 Pending 1 Yes 2 No death. iours after death.
nera! Director: A
filled in by the fu investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral Completely filled 29a. Certifier Mcertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier )56531 30. Name and address of person who co Vie - cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

10780

32. Registrar's Signature

Li,

JUL 2 0 2006

31. Date filed (M. nth, Day, Year)

Hickory Ridge Rd, Columbia, MD21044

|                            |   |                   | For State Registrer  | State of I  | Maryland / Dep<br><i>Ce</i>  | partment of Heartificate of De   | alth and Mo                                |  | ene 2 () () (                               | 5 22724   |
|----------------------------|---|-------------------|--|---|--|--|--|--|---|---|
|                            | Physicia<br>/Medic  | al                | 1. Decedent's Name (First, Middle, Li Brenda)  | E   | cton   | 4b. City, Town, or Lo  |  | 2. Date of Death<br>Month                | Day Year 1 Z 200 6  4c. County ol Dea       |   |
|                            | Examin  |                   | Social Security Number 6.  | land Med  | dical Center<br>Age (In yrs. last birthda                              | Baltimov II Under 1 Year   | e  | 8. Date of Birth<br>(Month, Day,         | 9. Bir                                      | I/A  httplace (State or Foreign ountry)                 |
| 6                          | Director works I show   | or                | 212-48-2573  Usual Residence of Decedent  10a. State   | V/A   | 10c. City, Town or   | Location Baltir  | more                                       | Dec 6, 19                                | 946   | Maryland  10d. Inside City Limits  Yes 2 □ No           |
|                            | with the A<br>3a or 28a-  | i Director        | 10e. Street and Number  1015 Sterrett Street   | Mag N   | 5.77   | 10f. Zip Code  | 21230                                      | 10                                       | g. Citizen of What C                        |   |
| 0036                       | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Plygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, Ite Modical Examiner must be notified at once. | d by Funeral      | 11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 █ Divorced   | 12. Was Decede<br>Armed Force<br>1  Yes 2<br>If Yes, Give<br>Year or Date | es?<br><b>X</b> No<br>es:  |  | Mexican, Puerto F<br>Specify:              | Rican, etc.)                             | 14. Race - Am<br>Black, Whi                 | Black   |
| Maryland 21215-0036        | ed within 72 h<br>giene.<br>er then "nstu<br>r the Modes.   | Completed         | 15, Decedent's (Specify only highest g  Elementary/Secondary (0-12)  12  |   | (Giv   | edent's Usual Occupation of work done during the NOT use retired)  Che | ef   | ng .                                     | 6b. Kind of Business Wayne                  |   |
| /land                      | should be file<br>and Mental Hy<br>s marksd oth<br>umatic svsnt   | To Be (           | 17. Father's Name (First, Middle, Las<br>Elmer   | t)<br>Thomas  |  | 11   | 8. Mother's Name                           |  | aiden Sumame)  Thomas                       |   |
|                            | and 2 sho<br>baith and in 27 is ma  |                   | 19a. Informant's Name/Relationship Terry White Daughter  | (Type, Print)   | 1  | iling Address (Street and<br>015 Sterrett Stre                         | et Baltimore,                              | Maryland 2                               | 1230  |   |
| Baltimore,                 | t. Pages 1. Iment of He tant: If Itsn   |                   | 20a. Method of Disposition  1 X Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec   | ify)  | ) W  | estern Cemetery  | 0  | 7/19/06                                  | Oc. Location - City or Baltimo              |   |
| Bal                        | permit. Departr Importi   |                   | 21. Signature of Funeral Service Life  | M. U  | alle   | → 1300 Euta  | thers Funeral<br>w Place Balti             | more, Md 2                               | 1217  |   |
|                            | Physician<br>/Medical   |                   | 23a. Pant1. Enter the disease, or co<br>shock, or head failure. List onl<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)          | y one cause on eac  | ised the death. Bo for each line.  I E u mon a  ras a consequence of): |  | such as cardiac of                         | r respiratory arres                      | st,   | Approximate Interval Between Onset and Death day 5      |
| 8760,                      | cate be executed physicien and the burial-transit   | ai Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or  | as a consequence of):  | ll cell lun  | g carc                                     | inoma                                    |   | months  |
| P.O. Box 687               | death certiff<br>e attending<br>ed for use as   | Physician/Medicai | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 25No 9 □ Unknown  |   | h 2 ☐ Fetal death 3<br>nt at time of death 5                           | B ☐ Ectopic pregnancy B ☐ Other (specify)                              |  |  | 23d. Date ol de<br>Month                    | olivery<br>Day Year                                     |
|                            | w requires that<br>s been signed I<br>s should be det   | ٥                 | Part II. Other significant conditions  | contributing to dea   | th but not resulting in the  | underlying cause given   | in Part I.                                 |  |   | to the cause of death?                                  |
| Division of Vital Records, | The la<br>ate has<br>page 2   | Completed         |  |   |  |  |  | 24a. Was an autopsy perform              | ed? death?                                  | utopsy lindings available completion of cause of s 2 No |
| Vita                       | Physicien: Th<br>this certificate<br>ral director, pag  | o Be              | 25. Was case referred to medicat examiner? 1 ☐ Yes 2 ☑ No  | Hospital: 1 Ning  | patient 2 ER/Outpat  | Dther  | 26. Place of Death                         | 7/                                       | nce 6 Other (Spe                            | ant d   |
| ion of                     | Attending Phy ir death. ector: After this by the funeral d  | ation: To         | 27. Manner of Death  1 X Natural 5 Pending 2 Accident investigat   | 28a. Date of<br>(Month,   |  | ol 28c. Injury a<br>Work?  |  | 8d. Describe how                         |   | эспу)   |
| Divis                      | al or Atts<br>s after dea<br>of in by th  | Certification:    | 3 Suicide 6 Could not 4 Homicide determine   | 288. Place 0  | f Injury - At home, larm,<br>, etc. (Specify)                          | street, lactory, office  | 2  | 281. Location (Stre<br>City or Town,     | eet and Number or R<br>State)               | Rural Route Number,                                     |
|                            | To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.   | edical            | 29a. Certifier 1 Certifying (Check only one) 2 Medical Ex  | Physician: To the baminer: On the bas<br>and manne                        | est of my knowledge, de<br>is of examination and/or<br>ir stated.      | ath occurred at the time,<br>investigation, in my opin                 | , date and place, a<br>nion, death occurre | and due to the car<br>ad at the time, da | use(s) and manner a<br>te and place, and du | is stated.<br>e to the cause(s)                         |
|                            | To the I within 2 To the Complete   | ×                 | 29b. Signature and title of certifier  Sum On A  | undy  | , MD   | 29c. License r   |  |  | d. Date signed (Mon                         |   |
|                            | 3   |                   |  | tandy, 1  | MD Univ  | levisity of M  | laryland                                   | Medical                                  | Center, B                                   | altimore, MD  |
|                            | Sta<br>Regist   | ate<br>rar        | 31. Date filed (Month, Day_Year)   | 006   | gistrar's Signature  | sile .   |  |  |   |   |

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day-Year)

2 0 2006

HERMAN

37 Registrar's Signature

|                                |  |                     | 1 - For State Registrar  | State of Maryland   |                       | artment of F  |                      | R  | leg. No.                                    | 22726  |
|--------------------------------|--|---------------------|--|---|-----------------------|---|----------------------|--|---|--|
|                                | Physici  | an                  | Decedent's Name (First, Middle, Last)  | Teddy Ellwood   | Easto                 | n   |                      | 2. Date of Dea<br>Month<br>July                      | Day 2006                                    | 3. Time of Death 9:55 A. M                       |
|                                | /Medic<br>Examin   |                     | 4a. Facility Name (If not institution, give str<br>Joseph Richey Hos   | reet and number)  |                       | 4b. City, Town, o   | r Location of D      |  | 4c. County of Dea                           |  |
| **                             | Funeral<br>Director  | ~                   | 5. Social Security Number 6. Sex   | 7. Age (In yrs. la  | ast birthday)<br>Yrs. | If Under 1 Year<br>Months Days  |                      | Hrs. 8. Date of Birth<br>Min. (Month, Day<br>Oct. 27 | 9. Bir<br>, 1963 Mai                        | chplace (State or Foreign<br>cuntry)<br>cyland   |
|                                | ryland   |                     | Usual Residence of Decedent  10a. State 10b. County  |   | , Town or Lo          |   |                      |  |   | 10d. Inside City Limits 1 ☐ Yes ※☐ No            |
|                                | the Ma   | recto               | Maryland   Anne Arur   | idel G  | len Bu                | rnie  |                      |  | 10g. Citizen of What Co                     |  |
|                                | 23a or   | al DI               | 7735 Baltimore A   | nnapolis Blvd   |                       |   | 060                  |  | U.S.  |  |
| 036                            | is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "neturel", or iteme 23a or 28a-f show other traumatic event, the Madical Examinational be putilised at   | by Funeral Director | 11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced  | 2. Was Decedent Ever in U.S<br>Armed Forces?<br>1 □ Yes 2基 No<br>If Yes, Give<br>Year or Dates: |                       | Was Decedent of Hif Yes, specify Cub                                      |                      | ? (Specify Yes or No-<br>uerto Rican, etc.)          | 14. Race - Ame<br>Black, Whi<br>Specify: Wh | te, etc.   |
| 1215-0                         | rithin 72 ho<br>ne.<br>hen "netur<br>e Madical I   | Completed           | 15. Decedent's Educa<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   |   | (Give<br>life.        | dent's Usual Occup<br>kind of work done<br>DO NOT use retire<br>anic / Do | during most of<br>d) |  | 16b. Kind of Business Automoti              |  |
| Baltimore, Maryland 21215-0036 | id be filed v<br>ental Hygie<br>ked other t<br>ic event, In  | To Be Co            | 11th  17. Father's Name (First, Middle, Last)  Norman  | Easton, Jr.   |                       | , -   | 18. Mother's         | Name (First, Middle,<br>rbara Edel                   | Maiden Sumame)                              |  |
| Mary                           | Ith and Milth an | -                   | 19a. Informant's Name/Relationship (Type<br>Barbara Day / Moth   |   |                       | ng Address (Street  |                      |  | r, City or Town, State, rnie, Mary1         |  |
| more,                          | Pages 1 ar<br>nent of Hea<br>int: if item<br>iry or other  |                     | 20a. Method of Disposition  1 □ Burial 2 🖾 Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)   | mayal from State  | emetery, cre          | osition (Name of<br>matory or other pla<br>Crematory                      |                      | Date 18/2006   | 20c. Location - City of Baltimore,          |  |
| Baltii                         | permit. Pages<br>Department of I<br>Important: if it<br>eny injury or o  |                     | 21. Signature of Funeral Service Lice to   | Daridge   |                       |   |                      |  | eral Servio<br>imore, Mar                   | ce, P.A.<br>yland 21225                          |
|                                | Physician  |                     | 23a. Part 1. Enter the disease, or complic<br>shock, or heart failure. List only one<br>Immediate Cause (Final<br>disease or condition | ations that caused the jeath<br>cause on each line.   | . 1                   | ter the mode of dy  | ng, such as car      | rdiac or respiratory ar                              | rest,                                       | Approximate Interval Between Onset and Death     |
| *                              | /Medical<br>Examiner   |                     | resulting in death)  | Due to (or as a consequ   |                       |   |                      |  |   |  |
|                                | uted<br>3<br>ansit   | Examiner            | Sequentially list conditions, Tany, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events  c.    | Due to (or as a cons.≱⊋   | uence of              |   |                      |  |   |  |
| ,097                           | ie be executed<br>ysicien and<br>e burial-transit  | cal Exa             | resulting in death) Last   | Due to (or as a consequ   | uence of):            |   |                      |  |   |  |
| . Box 68                       | Physician: The law requires that the death certificate b<br>this certificate has been signed by the attending physic<br>ral director, page 2 should be detached for use as the b   | Physiclan/Medl      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | ic. If yes, outcome of pregna<br>1 Live birth 2 Fetal<br>4 Pregnant at time of do<br>9 Unknown  | I death 3             | □Ectopic pregnand □ Other (specify) _                                     | ey .                 |  | 23d. Date of de<br>Month                    | olivery<br>Day Year                              |
| ds, P.O.                       | juires that t<br>n signed by<br>ild be detac   | by                  | Part II. Other significant conditions cont   | ributing to death but not res   | ulting in the t       | ınderlying cause gı   | ven in Part I.       |  | obacco use contribute<br>(es 2 No 3 F       | o the cause of death?                            |
| Vital Records,                 | The law require<br>ate has been si<br>page 2 should b  | Completed           |  |   |                       |   |                      |  | an 24b. Were a prior to death?              | utopsy findings available completion of cause of |
| Vita                           | ysician: The is certificate his director, page   | Be                  | 25. Was case referred to medical examiner?   | ospital:  | EB/Outentie           | -1 2/1 POA   O1   | hor                  | f Death   Check only o                               |   | Leave a  |
| of                             | To the Hospitel or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di   | atlon: To           | 1 Pes 2 No  27. Manper of Death 1 Natural 5 Pending 2 Accident investigation   | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury   | of 28c. Inju  | 4   140151           | 28d. Describe I                                      | dence 6 Other (Sp<br>now injury occurred    | HOSPICE  |
| Division                       | To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer   | Certification:      | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At he building, etc. (Specif   | ome, farm, si         | reet, factory, office   |                      | 28f. Location (S<br>City or Tox                      | Street and Number or F<br>vn, State)        | Rural Route Number,                              |
|                                | Hospite     24 hours     Funera     Intely fille   | Medical (           |  | ician: To the best of my kno<br>er: On the basis of examina<br>and manner stated.               |                       |   |                      |  |   |  |
|                                | To th<br>withir<br>To th<br>comp   | Me                  | 29b. Signature and title of certifier  |   |                       |   | se number            |  | 29d. Date signed (Mor                       |  |
| ,                              | 1  |                     | 30. Name and address of person who con   | mpleted cause of death (Item  | n 23a) (Tvna          | Print)  | 241                  |  | July 13, 2<br>were MD                       | 00b  |
| 5                              |  |                     | E ISO MD Richey  | Hospice 8   | 381                   | 1. Euta   | w st                 | Baltin   | were MD                                     | 21201  |
|                                | St<br>Regist   | ate<br>trar         | 31. Date filed (Month, Day, Year)  JUL 2 0 20  | 32. Registrar's Signa   | J.                    | parle   |                      |  |   |  |

7/13/3006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 8.11 per th 9857 7-20-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death BP+ **Physician** 2006 0600 110 toro /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bal timore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 M 2 F 215 5735 2 Yrs N.C. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: if Item 27 is marked other then "natural", or Items 23a or 28e-1 show ury or other traumatic event, the Madical Examinat must be publised at Baltimore Baltimore 1 0 8 2 □ No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21223 mall wood 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bugle Laundry 8th grade Shirt Presser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carter Yarborough Matthews ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If Item 27 is eny injury or other train once. Goddaughter 4335 Maryridge Dr., Randallstown, Md. 21133 Cynthia J. Heard 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-20-06 Loudon Park Cem. Baltimore, Md. 21. Signature of Funeral Service Licensée 22. Name and Address of Facility 21202 Baltimore, Md. March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit that initiated events resulting in death) Last the attending physiclen and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 10 No Month Year ō 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ So 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 7 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year, 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. ours after death.

neral Director: A
filled in by the fu 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗍 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 06 MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Entan #16 31. Date filed (Month, Day, Year) JUL 2 0 2005 3 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** William T. Freeman Jr. 12:36 AM 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Medical Baltimore Mercy Center If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 215-22-1536 Yrs. Director mari June Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside Ofty Limits Show r then "naturel", or itema 23a or 28a-f shov tre Medical Examiner is that be notified at 1 Yes 2 No Director MO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4552 filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Des 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race -1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Dlack þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Social Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. admin Xamene yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lipiry or other traumatic event page. William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) trand many L. Freeman WIFE Baeto md. 4552 The 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 706 forest vet. 21. Signature of Funeral Service License 22. Name and Address of Facility 270 Fred HILTON Tuneral done Finarch 23a. Party Enerthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or year failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Metastatic Colorectal Adenocarcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 3 Probably 4 □Unknown 1 Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an 1□ Yes 2 No I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? the funeral director, 26. Place of Death | Check only one Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 29a Contilla To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

JUL 2 0 2006

HEPP

31. Date fifed (Month, Day, Mar)

30. Name and addr s of person who completed cause of death (Item 23a) (Type, Print)

301



719729

MD

21202

July

9,2006

|       |   |                     | State of Maryland / Department of Health and  1 - State Registrer  Certificate of Death  |   | 2000  | 22729  |
|-------|---|---------------------|--|---|---|--|
|       |   |                     | Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)   | 2. Date of De                               |   | 3. Time of Death                                 |
| _     | Physici<br>/Medi  |                     | GEORGIA L. GUNBY   | July  | 15, 200 G   |  |
|       | Examir  |                     | 4a. Facility Name (If not institution, give street and number)  4b. City. Town, or Location of De  | eath  | 4c. County of Dea                                 | th   |
|       | Funeral   |                     | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H  |   | <b>N</b> A  | thplace (State or Foreign                        |
| 2     | Director  |                     | 253 · 40 · 2660 1 M 280 F 79 Yrs. Months Days Hours Mi   | in. (Month, Da                              | 127   | GA   |
| 3,    | and   |                     | Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location   |   |   | 10d. Inside City Limits                          |
| 7     | 1215-0036 within 72 hours after death with the Maryland ane. then "natural", or items 23s or 28s-f show the Madical Examenar must be notified at  | ctor                | MD NA BALTIMORE  |   |   | 1 X Yes 2 No                                     |
| 4     | with th   | by Funeral Director | 2111 ELUCOTI DRIVE WAY 2126  |   | 10g. Citizen of What Co                           | ountry?  |
| - 9   | death w   | erai                | 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?   | (Specify Yes or No                          |   |  |
| w     | 36 rs after death v I', or Itema 23   | Fur                 | 1 Never Married 2 Married 1 Yes 2 No If Yes Give 1 Yes 2 No Specify  | erto Hican, etc.)                           | Specific  |  |
| Secre | 5-0036 72 hours af  | ed by               | 3 ► Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation   |   | 16b. Kind of Business                             | ACK  |
| 0     | 215-<br>thin 72<br>e. "na   | piet                | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  Elementary/Secondary (0-12) College (1-4or 5+)   | working                                     | IGD. KING OF DUSINESS                             | moustry  |
| S     | d 212<br>filed with<br>Hygiene<br>outer the   | Completed           | 1274 GRADE N/A MACHINIST   |   | CLOTHING  |  |
| 0     | E BEB   | Be                  | 17. Father's Name (First, Middle, Last)  CHARLES BILINGSLEA  EUEN  EUEN  | lame (First, Middle,                        | Maiden Sumame)                                    |  |
| 3     | Maryla Id 2 should th and Men 17 ie marke   | 2                   | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or July 19b. Mailing Address)  |   | ar, City or Town, State, .                        | Zip Code)  |
| 4     | and and and and and and and and and and   |                     | PAMELA TURNER (DAUGHTER) 2111 ELLICOT DR. WAY  |   | . MD 2121   |  |
| Z     | A -1 = 2  |                     | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetary, crematory or other place)  20c. Place of Disposition (Name of cemetary, crematory or other place)   | Date  | 20c. Location - City or                           |  |
| 4     | Baltimol permit. Pages Department of Important: If I any injury or  |                     |  |   | owings m  |  |
| 4     | Deperm Perm Perm Perm Perm Perm Perm Perm P   |                     | 21. Signifure of Fundral Service Licensee VAUGHN C - GREENE F<br>5.151 BAUD. NAT: PI   | FUNERAL 8                                   | SERVICE<br>MO 21220                               |  |
| g     | 514   |                     | 23a. Part 1. Enlar he disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.   | liac or respiratory a                       | rrest,  | Approximate<br>Interval Between                  |
|       | Physician   |                     | Immediate Cause (Final disease or condition  Mya Cardial (ular   | chian                                       | i i   | Onset and Death                                  |
|       | /Medical<br>Examiner  |                     | Due to (or as a consequence of):   |   |   | 100  |
|       | *   | jer                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  |   |   |  |
| 6/11  | ocuted<br>nd<br>transit   | Examiner            | that inhibited events C.   |   |   | -  |
| 2     | 760, 0, te be executed spicien and se burial-transit  |                     | resulting in death) Last Due to (or as a consequence of):  |   |   | V-1  |
|       | A × 0   | edical              | d  |   |   |  |
|       | Box 68 leath certificat attending phy   | ician/Med           | IF FEMALE: 23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  |   | 23d. Date of de                                   | ,  |
|       | P.O. B<br>that the deal<br>ed by the att<br>detached fo   | Physicia            | In the past 12 months?  1 □ Yes 2 No 9 □ Unknown  1 □ Live birin 2 □ Fetal death 3 □ Ectopic pregnancy  4 □ Pregnant at time of death 5 □ Other (specify)  |   | Month   | Day Year   |
|       | S, P. es that t   | by Ph               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did t                                  | obacco use contribute to                          | the cause of death?                              |
|       | cords w require been sig  |                     | Coronary askery disease  | 10'   | Yes 2□No 3□Pr                                     | obably Unknown                                   |
|       | of Vital Records, Physician: The law requires tribis certificate has been signeral director, page 2 should be   | Completed           | end-Stage send distase   |   | osy prior to death?                               | utopsy findings available comptetion of cause of |
|       | of Vital Re<br>Physician: The la<br>r this certificete has  | 0                   | 25. Was case referred to medical 26. Place of D  | 1 ☐ Yes<br>Death (Check only o              | 2/3 No 1 Yes                                      | 3/2 No   |
|       | of V<br>hysic<br>this ce  | To B                |  |   | dence 6 Other (Spe                                | cify)  |
|       | On O<br>ding Ph<br>h.<br>After th<br>tuneral  | ion:                | 27. Manner of Ceath  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?  1   Yes 2   No   | 28d. Describe                               | now injury occurred                               | 3  |
|       | Division  or Attending after death.  Director: After  | ertification:       | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office  |   | Street and Number or Ri                           | ural Route Number,                               |
|       | Div<br>tal or<br>rs afte<br>al Dir<br>ed in b   | Cert                | 4 ☐ Homicide building, etc. (Specify)  | City or Tox                                 | vn, State)  |  |
|       | Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as it | edical              | 29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and plated and plate and pla | ace, and due to the<br>courred at the time, | cause(s) and manner as<br>date and place, and due | s stated.<br>to the cause(s)                     |
|       | To th<br>within<br>To th<br>compl   | Me                  | 29b. Signature and tyle of certifier 29c. License number   | 7   | 29d. Date signed (Mont                            | Day, Year)                                       |
|       |   |                     | Mundy / Mull My D 222.   | 19  | 11/5/   | 06   |
|       | S   |                     | Adrian Barbul Sinoi Hospital Boutin  | nore, M                                     | D. 21215  | ,  |
|       | St<br>Regist  | ate<br>trar         | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | -   |   |  |

|                            |   |                             | State of Manyland / Department of Health and   | •   | _  |  |
|----------------------------|---|-----------------------------|--|---|--|--|
|                            |   | 4                           | State of Maryland / Department of Health and Certificate of Death  | Reg. 1  | /1116                                    | 22730  |
|                            |   |                             | Registrar  1. Decedent's Name (First, Middle, Last)  | 2. Date of Death                                    | 40.                                      | 3. Time of Death                               |
|                            | Physicia  | n                           | Raymond J. Gough   | Month   | 15 2006                                  | 1207 PM  |
|                            | /Medic<br>Examin  |                             | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat  |   | 4c. County of Death                      | <u> </u>                                       |
| 1                          | LXdHill   | -1                          | Union Memorial Hospital Baltimore  |   | NIA                                      |  |
|                            | Funeral   |                             | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs  |   | 9. Birth                                 | place (State or Foreign intry)                 |
|                            | Director  |                             | 219-22-5544 18 M 2 F 78 Yrs. Mortins Days Hours Mill.  | 01/18/19  | 28                                       | MD   |
|                            | p ,   | -                           | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |   |  | 10d. Inside City Limits                        |
|                            | aho   | 2                           |  |   |  | 1 Nes 2 No                                     |
|                            | 28a-f   | ect                         | 10e. Street and Number 10f. Zip Code   | 10g (   | Citizen of What Cou                      | intry?   |
|                            | within 72 hours after death with the Maryland<br>ene.<br>Itan "natural", or itema 23a or 28a-f ahow<br>ha Modical Examiner must be covilled at  | Funeral Director            | 1910 E+ting St. 21217  |   | 5A                                       | , .  |
|                            | leath   | era                         | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer  |   | 14. Race - Amer                          |  |
| (0                         | riter   | 필                           | 1 Never Married 2 Married 1 XYes 2 No  | to Rican, etc.)                                     | Black, White                             | , etc.   |
| 21215-0036                 | ral', o   | ۵                           | 3 ■ Widowed 4 □ Divorced If Yes, Give Year or Dates:   |   | Specify: B                               | ack  |
| 2-0                        | 72 h  | Completed                   | 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wo   | 16b.  | Kind of Business/I                       | ndustry  |
| 21                         | ithin   | du.                         | Elementary/Secondary (0-12) College (1-4or 5+)   | 24/   | D  | ,  |
|                            | filed w<br>Hygiei<br>other ti   |                             | 17. Father's Name (First, Middle, Last)  18. Mother's Nai  | me (First, Middle, Maid                             | on Sumame UN                             | 3  |
| anc                        | be find the of ot   | Be                          | Ch. No.  |   | on opmano, -                             |  |
| Maryland                   | 2 should be filed within<br>and Mental Hygiene.<br>ie marked other then<br>aumatic avant, the Ma  | ၉                           | Albert L. (2009)  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ri  |   | v or Town, State, Z                      | ip Code)                                       |
| <b>≥</b>                   | s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If Health and Mental Hygiene a fathow the marked other than "natural", or itema 23a or 28a-f show other traumatic avant, the Medical Examiner must be multified at | 1                           |  | Himore, M   | 10 21215                                 |  |
| ē,                         | permit. Pages 1 and 2<br>Department of Health a<br>Important: if Itam 27 is<br>any injury or other tra  |                             | 20a. Method of Disposition 20b. Place of Disposition (Name of  |   | Location - City or 1                     | Town, State                                    |
| Baltimore,                 | Page<br>lent o<br>nt: if<br>ry or   |                             |  | 24/2006 Du  | sings Mil                                | IS MD  |
| alti                       | permit. Pa<br>Departmen<br>important:<br>any injury<br>once.  |                             | 21. Signature of Funeral Service Licensee 22. Name, and Address of Facility  | Funeral Sh  | <u>c</u>                                 |  |
| m                          | Ped de de de de de de de de de de de de d   |                             | 21. Signature of Funeral Service Licensee  Vouch  C. Greene  5151 Patro Xatt P. I  | Ke, Baltimor  | e MD 2                                   | 1229   |
|                            |   |                             | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.  | ic or respiratory arrest,                           |  | Approximate<br>Interval Between                |
| 1                          | Physician :   |                             | Immediate Cause (Final disease or condition Coronary Artery Disease  |   |  | Onset and Death                                |
|                            | /Medical<br>Examiner  |                             | Due to (or as a consequence of):   |   |  |  |
|                            | - Adminion  | ٠,                          | Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):  |   |  |  |
| ۵.                         | ted<br>1sit   | Examiner                    | cause. Enter Underlying<br>Cause (Disease or injury  |   |  |  |
| مر                         | xecur<br>and<br>al-trar   | xan                         | that initiated events c  |   |  |  |
| 760,                       | certificate be executed ding physicien and use es the burial-transit  | cal                         | d  |   |  |  |
| .89                        | death certificate t<br>ettending physicate to the total   |                             |  |   | 7  |  |
| Box                        | h cer<br>endin  | N/UE                        | IF FEMALE: 23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  |   | 23d. Date of deli                        |  |
|                            | 0 6 2   | sicia                       | in the past 12 months?  4 □ Pregnant at time of death 5 □ Other (specify)  |   | Month                                    | Day Year                                       |
| P.0                        | ac =  | Completed by Physician/Medi | 9 Unknown  | 23a Did tobaco                                      | o uso contributa to                      | the cause of death?                            |
|                            | 8 5 0   | þ                           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | . /   |  | bably 4 []Unknown                              |
| 5                          | w requires<br>been sign<br>should be  | etec                        |  |   |  |  |
| 3ec                        | e la<br>hes<br>je 2   | mpi                         |  | 24a. Was an autopsy performed                       | prior to death?                          | topsy findings available ompletion of cause of |
| a                          | ilcien: The i<br>certificete he<br>rector, page   |                             | Of West and address of the Control o | performed   | No 1 ☐ Yes                               | 2 🗆 No   |
| ξ                          |   | o Be                        | ovaminor?  | eath (Check only one) Home 5 TResidence             | 6 □Other (Sacr                           | 164)   |
| of                         | Physer this eral di   | n: To                       | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at  | 28d. Describe how in                                |  | ny)  |
| ion                        | Attending F<br>r death.<br>ector: After<br>by the funera  | atio                        | 1 Matural 5 Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No   |   |  |  |
| Division of Vital Records, | er des<br>recto<br>by th  | Certification:              | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   | 28f. Location (Street<br>City or Town, St           |  | ral Route Number,                              |
| Ö                          | rs aft  | Cer                         |  |   |  |  |
|                            | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu  | edical                      | 29a. Certifier  (Check only  (Check only  (Check only)  (Check only  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  (Check only)  | e, and due to the cause<br>curred at the time, date | e(s) and manner as<br>and place, and due | stated.<br>to the cause(s)                     |
|                            | the the mplet   | Med                         | one) and manner stated.  29b. Signature and title of certifier 29c. License number   | 29d.  | Date signed (Month                       | . Dav. Year)                                   |
|                            | 8 7 8 7   |                             | I Igor BelyANSKY 222943  |   |  | 2006   |
|                            | 0   |                             | 30. Name and address of person who completed cause of death (Item 23a) (Type Print)  |   | - 0                                      |  |
|                            | 8   |                             | Igar BeyAnsky, M.D. Union Memoria  31. Date filed (Month, Day, Year)  32. Registrar's Signature  | 1 Hospital  | MD                                       |  |
|                            |   |                             |  |   | /  |  |
|                            | Sta   | te                          |  |   |  |  |
|                            | Sta<br>Registi  |                             | JUL 2 0 2006   |   |  |  |

DHMH 17 Rev 1/2001

ORIGINAL

|                   |  |                               | For State Registrar  | State of Maryland / De<br>C  | partment of Health and ertificate of Death   |   | ene 2006  | 2273   |
|-------------------|--|-------------------------------|--|--|--|---|---|--|
|                   | Physici  |                               | Decedent's Name (First, Middle, Last)  John  | C. Garvey  |  | 2. Date of Death<br>Month July<br>June                      | 8,2006 Year                                       | 3. Time of Death 10:30 pM                          |
|                   | /Medic<br>Examin   |                               | 4a. Facility Name (If not institution, give s  Casey House   |  | 4b. City, Town, or Location of Deat<br>Rockville   | th  | 4c. County of Death Montgome                      | ery  |
|                   | Funeral<br>Director  | 1                             | 5. Social Security Number 6. Sex 179-14-8522   | M 2□F 7. Age (In yrs. last birthda   | Months Days Hours Min.   |   | 9. Birthp<br>921 Pen                              | lace (State or Foreign<br>try)<br>na •             |
|                   | Maryland -f show   | tor                           | Usual Residence of Decedent  10a. State MD  10b. County Montgome   | ery Burton   |  |   | 1   | 0d. Inside City Limits 1 ☐ Yes 2 No                |
|                   | th with the<br>23s or 28s  | ai Direc                      | 10e. Street and Number 3415 Greencast]   | Le Road  | 10f. Zip Code<br>20866   | 100   | g. Citizen of What Coun<br>USA                    | try?   |
| 036               | permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23e or 28e-f show important: If item 27 is marked other than "natural", or iteme 23e or 28e-f show any injury or other treumatic avent, the Madical Examinal must be notified at Once. | Completed by Funeral Director | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?  1   | <ol> <li>Was Decedent of Hispanic Origin? (5<br/>If Yes, specify Cuban, Mexican, Puer<br/>1 ☐ Yes 2 No Specify:</li> </ol> | Specify Yes or No-<br>to Rican, etc.)                       | 14. Race - Americ<br>Black, White,<br>Specify: Wh |  |
| 21215-0036        | within 72 ho<br>ene.<br>than "natu<br>be Madical   | ompieted                      | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)  | College (1-4or 5+)   | ocedent's Usual Occupation<br>live kind of work done during most of wo<br>e. DO NOT use retired)<br>ofessor Emeritus       | rking   | Sb. Kind of Business/Inc                          | dustry   |
| Maryland 2        | uld be filed<br>Jental Hygi<br>rked other<br>filc avent, I   | To Be Co                      | 17. Father's Name (First, Middle, Last) Frank Garvey   | <u> </u>   |  | me (First, Middle, Ma<br>Geggenh                            |   |  |
| , Mary            | end 2 sho<br>selth and h<br>n 27 is ma   |                               | 19a. Informant's Name/Relationship (Ty)<br>Deirdre Ann Gary  | vey/Daughter 2   | ailing Address (Street and Number or R<br>9000 Naylor Dri  |   |   |  |
| Baltimore,        | . Pages 1<br>tment of He<br>tant: If iten  |                               | 20a. Method of Disposition  1  Burial 2  Coremation 3  R 4  Donation 5 Other (Specify)   | emeval from State Chesa  |  | 0/06  | oc. Location - City or To<br>Beltsvill            | e,Md   |
| Bat               | permit<br>Deper<br>impor<br>any in   |                               | 21. Signatur for Funeral Service License   | eldr   | PHILIPADS RINALD<br>9241 Columbia E  | Blvd.Silv   | er Sprin  | g,Md20910  |
| January)          | Physician<br>/Medical<br>Examiner  |                               | 23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)              | e cause on each line.  | ructive Pulmonar   |   |   | Approximate Interval Between Onset and Death 4 yrs |
| 98760,            | ficate be executed in physicien and the burial-transit   | dical Examiner                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of):  Due to (or as a consequence of):                                     |  |   |   |  |
| P.O. Box 68       | death certi<br>e ettending<br>id for use a   | Physician/Med                 | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  | 3c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown     | 3 Ectopic pregnancy 5 Other (specify)  | - 22-0AA h  | 23d. Date of delive<br>Month                      | ory<br>Day Year                                    |
|                   | .≘ w +9  | by                            | Part II. Other significant conditions con<br>Congestive Hea  |  | e underlying cause given in Part I.  |   | cco use contribute to the                         |  |
| of Vital Records, |  | Completed                     |  |  |  | 24a. Was an<br>autopsy<br>performe<br>1 \( \text{Yes} \) 24 | prior to cor                                      | psy findings available inpletion of cause of       |
| f Vita            | Physicien: This certifice ral director, p  | To Be                         | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No  | fospital: 1 Inpatient 2 ER/Outpa   |  | eath <i>(Check only one)</i><br>Home 5 🗆 Residen            | ce 6 🛛 Other (Specifi                             | hospice  |
| Division o        | fing<br>After  |                               | 27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation  | 28a. Date of Injury<br>(Month, Day Year) 28b. Tim  | e of 28c. Injury at  | 28d. Describe how   |   |  |
| Divis             | Hospital or Attence to hours effer death Funeral Director: tely filled in by the   | Certification                 | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of Injury - At home, farm building, etc. (Specify)  | , street, factory, office  | 28f. Location (Stre<br>City or Town,                        | et and Number or Rura<br>State)                   | l Route Number,                                    |
|                   | To the Hospital or At within 24 hours effer or To the Funeral Directompletely filled in by   | ledicai                       | 29a. Certifier 1 X Certifying Physic (Check only one) 2 Medical Examination  | sician: To the best of my knowledge, d<br>nar: On the basis of examination and/o<br>and manner stated. | leath occurred at the time, date and place investigation, in my opinion, death occurrence.                                 | e, and due to the cau<br>urred at the time, dat             | se(s) and manner as st<br>e and place, and due to | ated.<br>the cause(s)                              |
|                   | To the within 2 To the complet   | ×                             |  | signel   | 29c. License number D42452   | 290   | 1. Date signed (Month, July 19,                   |  |
|                   | Y  |                               | 30. Name and address of person occ<br>Chitra Rajagopa  | 1 MD 6001 Mund   | caster Mill Rd.  | Rockvil   | le,Md 208   | 55   |
| Di                | St<br>Regist   |                               | 31. Date filed (Month, Day, Year)  JUL 2 0 20  | 06 32. Togistrar's Signature   | Conti  |   |   |  |

DHMH 17 Rev 1/2001

|                                |  |                     | For<br>State<br>Registrar  | State of Marylai  |  |                         | t of Heal   |  |                                       | Reg. No.                   | 2006   | - to 1 O 1.   |
|--------------------------------|--|---------------------|--|---|--|-------------------------|---|--|---------------------------------------|----------------------------|--|---|
|                                | Physicia   | _                   | Decedent's Name (First, Middle, Last)  |   |  |                         |   |  | 2. Date of De<br>Month                | ath<br>Day                 | Year   | 3. Time of Death  |
|                                | /Medic   | al                  |  | C. Horn   |  | 41- 07-                 | Taura and and   | stine of Dooth                             | 07                                    | - 20                       | - Olo  | (0:10ª M  |
|                                | Examin   | er                  | 4a. Facility Name (If not institution, give s  | 1   |  | 4b. City,               | Town, or Loca   | ation of Death                             |                                       | 7)                         | ounty of Death                               |   |
|                                | Funeral  |                     | 5. Social Security Number 6. Sex 212-32-7071   |   |  | If Under<br>Months      | 1 Year If U   | Inder 24 Hrs.<br>ours Min.                 | 8. Date of Bird<br>Month 29           | th Year 3                  | 9. Birth<br>7 Mai                            | pplace (State or Foreign<br>intry<br>ryland                     |
|                                | Director   | }                   | Usual Residence of Decedent  |   |  |                         |   |  | 1 3                                   | ,                          |  | 1   |
|                                | Maryland<br>-f ehow<br>fied at   | tor                 | 10a. State 10b. County MD Baltim   |   | ity, Town or Lo<br>Ess                     |                         |   |  |                                       |                            |  | 10d. Inside City Limits 1 ☐ Yes 2 ☐ÑNo                          |
|                                | s with the   | i Direc             | 10e. Street and Number 5 Woody Road  | 1   |  | 10f. Zip                | Code 2121   |  |                                       | 10g. Citize                | en of What Cou                               | untry?  |
| 036                            | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene.  In any injury or other traumatic event, the Medical Evantmer must be notified at ODE. | by Funeral Director | 11. Marital Status  1 Never Married 2X Married  3 Widowed 4 Divorced   | 12. Was Decedent Ever in t<br>Armed Forces?<br>1                                  |  | Was Dece<br>f Yes, spe  |   | ic Origin? (Sp<br>exican, Puerto<br>ecify: | ecify Yes or No<br>Rican, etc.)       | ŀ                          | 4. Race - Amer<br>Black, White<br>Specify: W |   |
| Baltimore, Maryland 21215-0036 | within 72 ho<br>sne.<br>than "natur<br>e Medical   | Completed           | 15. Decedent's Edu<br>(Specify only highest grade<br>Elementary/Secondary (0·12)   |   | (Give                                      | kind of wo<br>DO NOT u  | al Occupation<br>ork done during<br>se retired)<br>ntende |  | ing                                   | Bal                        | timore                                       | e County  |
| land 2                         | uld be filed vental Hygierked other tic event, it  | To Be Co            | 17. Father's Name (First, Middle, Last) William P. Ho  |   | Jup  | )CI 11                  | 18. 1   | Mother's Nam                               | e (First, Middle,<br>et Him           | Maiden S                   | umame)                                       | JIN5  |
| Mary                           | nd 2 shou<br>lith and N<br>27 is mai   |                     | 19a. Informant's Name/Relationship (Ty, Maryann H. Horr  |   |  | -                       |   |  | al Route Number<br>timore             |                            |  | ip Code)  |
| more,                          | Pages 1 are not of Hee not: If item iry or othe  |                     | 20a. Method of Disposition  1 XBurial 2 Cremation 3 R  4 Donation 5 Other (Specify)  | emoval from State 20b.  | Place of Dispo<br>cemetery, cren<br>ardens | sition (Nai             | Faith   | 7/2  | Date 4/06                             |                            | ation - City or T                            |   |
| Balti                          | permit. Departmimports any inju  |                     | 21. Signature of Funeral Service License   | Conne   | ////                                       |                         | and Address of B  | 30   | 0 Mace<br>1 Home                      | Ave<br>of                  | . Balt<br>Essex                              | O. MD<br>21221  |
|                                | Physician<br>/Medical  |                     | 23a. Part1. Enter the disease, or compare shock, or heart failure. List only of the disease or condition resulting in death)                               | cations that caused the deane cause on each line.  Due to (or as a conse          | ader                                       |                         | ccinol  |  | or respiratory a                      | rrest,                     |  | Approximate Interval Between Onset and Death  Jears             |
|                                | physicien and sthe burial-transit  | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conse   |  |                         |   |  |                                       |                            |  |   |
| Box 68760,                     | feath certificate be<br>ettending physici<br>I for use as the bu   | ın/Medicai          | IF FEMALE: 23b. Was decedent pregnant  | f.<br>3c. tf yes, outcome of pregr<br>1 ☐ Live birth 2 ☐ Fet                      |  | ]Ectopic p              |   |  |                                       | 23                         | 3d. Date of deliv                            | •   |
| P.O. B                         | the deat   | Physician/Med       | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 4☐ Pregnant at time of 9☐ Unknown   |  | Other (sp               |   |  |                                       |                            | Month  | Day Year  |
|                                | e lew requires that the death certifica<br>hes been signed by the ettending pl<br>je 2 should be detached for use as i   | þ                   | Part II. Other significant conditions con Septic Shock   | ntributing to death but not re  | sulting in the ur                          | nderlying o             | ause given in   | Part I.                                    | 23e. Did t                            |                            |  | the cause of death?   |
| I Records,                     | The<br>ate h<br>page   | Completed           | _Cardio myopa  | thy   |  |                         |   |  | 24a. Was<br>autor<br>perfo<br>1 ☐ Yes | an<br>osy<br>rmed?<br>2 No | 24b. Were aut prior to codeath?              | opsy findings available ompletion of cause of 2 \( \square\$ No |
| /ita                           | ician: Th<br>certificate<br>rector, pag  | Be (                | 25. Was case referred to medical examiner?   |   |  |                         |   | Place of Deat                              | h (Check only o                       | ne)                        |  |   |
| n of \                         | ng Physician:<br>fter this certifici<br>ineral director.   | on: To              | 1 ☐ Yes 2 ② No  27. Manner of Death 1 ② Natural 5 ☐ Pending  | lospitat: 1 Anpatient 2 C<br>28a. Date of trijury<br>(Month, Day Year)            | ER/Outpatien<br>28b. Time of<br>tnjury     |                         | OA Other: 4<br>28c. Injury at<br>Work?                    | ☐ Nursing Ho                               | ome 5 Resident                        |                            |  | ify)  |
| -                              | f or Attending<br>after death.<br>Diractor: After<br>in by the fune  | Certification:      | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury - At building, etc. (Spec                                    | home, farm, str                            | M<br>eet, factor        | 1 ☐ Yes<br>y, office                                      | 2 🗆 No                                     | 28f. Location (S<br>City or Tox       |                            | Number or Rui                                | ral Route Number,   |
|                                | To the Hospitel or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.   | cai                 | 29a. Certifier 11% Certifying Physic (Check only one)  | sician: To the best of my kr<br>ner: On the basis of examin<br>and manner stated. | nowledge, death                            | occurred<br>vestigation | at the time, da   | ate and place,<br>n, death occur           | and due to the red at the time,       | cause(s) a<br>date and p   | ind manner as<br>place, and due              | stated.<br>to the cause(s)                                      |
|                                | o the<br>ithin 2<br>b the  | Medi                | 29b. Signature and title of certifier  | and mainer stated.  |  | 29                      | c. License nun  | nber                                       |                                       | 29d. Date                  | signed (Month                                | , Day, Year)  |
|                                | F ≥ F 8  |                     | Milson   | and C   |  |                         | ) Ø Ø (   |  |                                       | T. 1.                      |  | 2006  |
| <b>1</b> 161                   | ٩  |                     |  | ompleted cause of death (the  |  | Print)                  |   |  | 2104                                  | 3                          | $f = \omega_1$                               | 2006  |
|                                | Sta<br>Registi   | _                   | Majid Cina, ND, 84 31. Date filed (Month, 19av. Year) 20   | 32. Physistrar's Sign   | nature                                     | - W                     | or car  | 7,   | 210 4                                 |                            |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maniland / Danartment of Health and Mantal His

|                            |   |                | For<br>State<br>Registrar   | State of Maryland / Depa  | irtment of Health and Iv<br>tificate of Death   | ientai Hygier<br>Reg. f                        | /1115                                   | 22733  |
|----------------------------|---|----------------|---|---|---|--|---|--|
|                            | Physici   | an             | 1. Decedent's Name (First, Middle, Last   | ee Hayes  |   | 2. Date of Death<br>Month                      | Day, Year                               | 3. Time of Death                                   |
| }                          | /Medic<br>Examir  | al             | 4a. Facility Name (If not institution, give   |   | 4b. City, Town, or Location of Death  |  | 4c. County of Death                     |  |
|                            | Exami   |                |   | edical Center   | Baltimore   |  |   | N/A  |
|                            | Funeral<br>Director   |                | 218-03-2328   | x 7. Age (In yrs. last birthday)  M 2□ F  | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.                                | 8. Date of Birth<br>(Month, Day, Yea           | 9. Birth<br>Con                         | nplace (State or Foreign untry)                    |
|                            | land<br>bw  |                | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, Town or Lo   | cation  |  |   | 10d. Inside City Limits                            |
|                            | a-f sh  | ctor           | A/N GM  | Baltimo   | Re  |  |   | 1 X Yes 2 □ No                                     |
|                            | vith the  | Director       | 10e. Street and Number  | λ   | 10f. Zip Code   |  | Citizen of What Co                      | untry?   |
|                            | death with the Maryland<br>me 23a or 28a-f show<br>r must be notified at  | erai           | 2328 Edmono   | 12. Was Decedent Ever in U.S. 13. \   | Alaa3  Was Decedent of Hispanic Origin? (Spir Yes, specify Cuban, Mexican, Puerto       |  | 14. Race - Amer                         |  |
| 980                        | be filed within 72 hours after death with the Marylan<br>lat Hygiene.<br>Id other then "natural", or fleme 23a or 28a-f show<br>death, the Medical Examiner must be notified at | by Funeral     | 1 Never Married 2 Narried 3 Widowed 4 Divorced  | 1 XX Yes 2 ☐ No   | f Yes, specify Cuban, Mexican, Puerto<br>□ Yes 2 <b>爲</b> ,No <i>Specify:</i>           | Rican, etc.)                                   | Specify:                                | ack  |
| у<br>О                     | 72 ho   | eted           | 15. Decedent's Edu<br>(Specify only highest grad  | reation 16a. Decede (Give   | lent's Usual Occupation<br>kind of work done during most of work<br>DO NOT use retired) | ing 16b.                                       | Kind of Business/I                      | ndustry  |
| 21215-0036                 | within<br>ene.<br>then  | Completed      | Elementary/Secondary (0-12)   | College (1-4or 5+)  | O 1   |  | overlan                                 | Dairy  |
|                            | other   | Be Co          | 17. Father's Name (First, Middle, Last)   |   | 18. Mother's Name   | (First, Middle, Maid                           |   | 1 20117  |
| ylar                       |   | TOE            |   |   | Sallie  | Kobins   |   |  |
| Maryland                   | s 1 and 2 should<br>f Health and Mer<br>item 27 le marke<br>other treumetic   |                | 19a. Informant's Name/Relationship (T)  | (pe, Print) 19b. Mailin   | g Address (Street and Number or Rura  | al Route Number, City                          | y or Town, State, Z                     | 0.44   |
| Baltimore,                 | B = 5   |                | 20a. Method of Disposition  1 Burial 2 Cremation 3 I  | Removal from State  | sition (Name of anatory or other place)   | Date 20c.                                      | Location - City or 1                    |  |
| Ħ                          |   |                | 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens   | GARISE 122  | Name and Address of Facility  | 2006 0   | sings M                                 | IIS, MD  |
| B                          | permit. Departrimports eny inju   |                | Youghn C  | Greene 5  | Name and Address of Facility  AUGM C Grene F  | The Balt                                       | more MI                                 | 21229  |
| 1                          | Physician<br>/Medical   |                | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only o<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | lications that caused the death. Do not entine cause on each line.  a   | er the mode of dying, such as cardiac (   | or respiratory arrest,                         |   | Approximate<br>Interval Between<br>Onset and Death |
| ı                          | Examiner  |                | Sequentially list conditions,   | b. ————————————————————————————————————   |   |  |   | one Week   |
| D.                         | t<br>Insit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as a consequence of):  |   |  |   |  |
| 0,0                        | ificate be executed<br>g physician and<br>as the burial-transit   |                | that initiated events resulting in death) Last  | Due to (or as a consequence of):  |   |  |   |  |
| 09289                      | cate b<br>physic<br>the bi  | edical         |   | d   |   |  |   | N-27-70-2  |
| Box                        | The law requires that the death certifier has been signed by the attending tage 2 should be detached for use as   | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  |   | Ectopic pregnancy Other (specify)   |  | 23d. Date of delin                      | v <b>ery</b><br>Day Year                           |
| P.O.                       | that the  |                |   | ntributing to death but not resulting in the ur   | nderlying cause given in Part I.  | 23e. Did tobacc                                | o use contribute to                     | the cause of death?                                |
| rds                        | w requires<br>been signi<br>should be   | ed by          |   |   |   | 1 🗆 Yes  | 2 □ No 3 □ Pro                          | bably 4XUnknown                                    |
| Division of Vital Records, | The law requisate has been page 2 shoul   | Completed      |   |   |   | 24a. Was an autopsy performed:                 | prior to c<br>death?                    | opsy findings available ompletion of cause of      |
| /ita                       | ician:<br>certifica<br>rector, p  | Be             | 25. Was case referred to medical examiner?  | Aia-t.  |   | (Check only one)                               |   |  |
| of                         | Phys<br>this<br>al di   | - To           | 1 ☐ Yes 2 No 27. Manner of Death  | Hospital: 1 Inpatient 2 ER/Outpatien 28a. Date of Injury 28b. Time of   |   | me 5 Residence<br>28d. Describe how in         |   | ıfy)   |
| ion                        | nding l<br>ath.<br>r: After<br>e funer  | atlon          | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation   | 28a. Date of Injury<br>(Month, Day Year) 28b. Time of<br>Injury   | 28c. Injury at Work?  M 1 Yes 2 No  | 200. 2000. 20 11011 111                        | july 55551104                           |  |
| Divis                      | Hospital or Attending<br>4 hours after death.<br>Funeral Director: After<br>tely filled in by the funer   | Certification: | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Injury - At home, farm, strubuilding, etc. (Specify)  | eet, factory, office  | 28f. Location (Street<br>City or Town, Sta     |   | ral Route Number,                                  |
|                            | To the Hospital or A within 24 hours after To the Funeral Direction completely filled in b  | Medical C      | 29a. Certifier 1 Certifying Phy<br>(Check only 2 Medical Exam   | rsician: To the best of my knowledge, death<br>iner: On the basis of examination and/or inv<br>and manner stated. | occurred at the time, date and place,<br>restigation, in my opinion, death occurr       | and due to the cause<br>ed at the time, date a | (s) and manner as<br>and place, and due | stated,<br>to the cause(s)                         |
|                            | To the vithin 2 To the complet  | Me             | 29b. Signature and title of certifier   |   | 29c. License number   |  | Date signed (Month                      |  |
|                            |   |                |   | M.D.  | P19795  | Ju   | 114 14                                  | 2006   |
|                            | 11  | 1              |   | ompleted cause of death (Item 23a) (Type,<br>Wala ION, GYE  | Print)<br>L'ene Street F  | zaltimo  | re. Mr                                  | 21201  |
|                            | St  | ate            | 31. Date filed (Month, Day, Year)   | 32. Registrar's Signature   | .0110 011.001   | J + 1 1 1 1 0                                  | ) 1410                                  | 01001  |

State Registrar

DHMH 17 Rev 1/2001

JHL 2 0 2006

32. Registrar's Signature

ORIGINAL

|   |                               | For<br>State<br>Registrar  | State of Maryland   |   | ent of Hate of L  |                                 | nd Me     |   | iene 2             | 006                                   | 2273   |
|---|-------------------------------|--|---|---|---|---------------------------------|-----------|---|--------------------|---------------------------------------|--|
| Physicia<br>/Medic  |                               | 1. Decedent's Name (First, Middle, Last)   | Hackett   |   |   |                                 |           | 2. Date of Death<br>Month<br>©7                     | Day                | Year<br>2006                          | 3. Time of Death                               |
| Examin<br>Funeral<br>Director   |                               | 4a. Facility Name (If not institution, give Gilchest Hosp 5. Social Security Number 6. Sec. 219-38-7901  | ice   | B   | Olty, Town, or<br>Oltim<br>nder 1 Year<br>ths Days                              | DRE If Under 24 Hours           | Ci        | B. Date of Birth<br>(Month, Day,                    | 1                  | 9. Birthp                             | lace (State or Forei                           |
| Ö   | tor                           | Usual Residence of Decedent  10a. State  10b. County  N/A  | 10c. City   | Town or Location  | >   |                                 |           |   | 1912               | 1                                     | 0d. Inside City Limi                           |
| be filed within 72 hours after death with the Maryland stal Hyglene.  do other then "naturel", or Iteme 23a or 28a-f ehow event, the Medical Examinar must be notified at | Completed by Funeral Director | 10e. Street and Number  22 42 Madison  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad  |   | 10d   10d | Zip Code  2/2/7 ecedent of Hi specify Cuba es 2 No  Usual Occupa f work done of | Specify:                        |           | ify Yes or No-<br>ican, etc.)                       | ISA<br>14. F       | Race - Americ<br>Black, White, ocity: | an Indian,<br>etc.                             |
| 2 should be filed within<br>and Mental Hygiene.<br>Is marked other then "<br>aumatic event, the Mec   | To Be Compl                   | Elementary/Secondary (0-12)  Frade  17. Father's Name (First, Middle, Last)  William Pend  | College (1-4or 5+) NA   | Home  | nake  | R<br>18. Mother:<br>Edry        | 2 1       | (First, Middle, N                                   | 200                | ,                                     |  |
| of Heelth<br>of Heelth<br>of Item 27<br>ir other tr   |                               | 19a. Informant's Name/Relationship (T)  Pach + A Pack E  20a. Method of Disposition  1 B Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  | 20b. PI   | ace of Disposition<br>emetery, crematory  | FFo\K !   | DR. H                           | Da        | rstown,   | MD<br>20c. Locatio | 21742<br>on - City or To              | wn, State                                      |
| permit. Pag<br>Depertment<br>Important: I   |                               | 21. Signature of Funeral Service Licens  | Greene  | 22. Nam<br>Voud<br>5151   | and Address<br>An C<br>Balto  | is of Facility<br>Green<br>Noth | re f      | 2006 d<br>Funeral<br>Baltimo                        | EVC<br>Dec. M      |                                       | <i>229</i>                                     |
| Physician<br>/Medical<br>Examiner   | ner                           | 23a, Part1. Enter the disease, or complishock, or heart fallure. List only of Immediate Cause (Final disease or condition resulting in death)  Securitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) | Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)                    | failur  |   |                                 | ardiac or | respiratory arre                                    |                    |                                       | Approximate Interval Between Onset and Death   |
| The law requires that the death certificate be executed ste hes been signed by the attending physician and page 2 should be detached for use as the burial-transit        | Physician/Medical Examiner    | resulting in death) Last   | Due to (or as a consequent).  3c. If yes, outcome of pregnant 1 Live birth 2 Fetal 4 Pregnant at time of de | ncy<br>death 3 ⊟Ectop   | ic pregnancy  |                                 |           |   | 1                  | Date of delive<br>Month               | ory<br>Day Year                                |
| juires that the de<br>n signed by the a<br>lid be detached i  | Ď                             | 9 ☐ Unknow(  Part II. Other significant conditions co  | 9□ Unknown  |   |   | en in Part I.                   |           | 23e. Did tob  | \ \                |                                       | e cause of death?                              |
| ilcien: The law requir<br>certificete hes been si<br>rector, page 2 should  | e Completed                   | 25. Was case referred to medical   |   |   |   |                                 |           | 24a. Was ar<br>autopsy<br>perform<br>1 Yes 2        | No No              | prior to con<br>death?                | psy findings availant pletion of cause of 2 No |
| ding Phys   | 70 B                          | avaminar?  | Hospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Input 28a. Date of Injury (Month, Day Year)     | ER/Outpatient 3E<br>28b. Time of<br>Injury  | DOA Othe  | er: 4 ☐ Nurs                    | sing Hom  | Check only only<br>e 5 ☐ Resider<br>8d. Describe ho | nce 6              |                                       | hospiy   |
| Atter<br>or dea<br>octor<br>by the  | il Certification:             | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At ho building, etc. (Specify  | ")  | ctory, office   |                                 | 28        | City or Town  | , State)           |                                       | l Route Number,                                |
| To the Hospital or within 24 hours afte To the Funeral Dir completely filled in   | Medical                       | (Check only one)  29b. Signature and title of gertifier  | ner: On the basis of examinat and manner stated.  | ion and/or investiga  | ation, in my op   | oinion, death<br>o number       | occurre   | d at the time, da                                   | te and place       | pned (Month, I                        | the cause(s)  Day, Year)                       |
| Str   | ate                           | 30. Name and addr ss of person who co  | ompleted cause of death (Item  ANAS 6601  32. Refistrar's Signal  | N, Ct   | rar le  | 5 5                             | f         | Barn  | nre                | NO 2                                  | 2/204  |

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Willis Hershberger 18:44 2006 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth AMPUS EGANY 5. Social Security Number if Under 1 Year 8. Date of Birth (Month, Day, Dec 25, 9. Birthplace (Stete or Foreign Country) West Virginia 7. Age (In yrs. last birthday) 1₩ 2□ F Days Hours Months 72 213-24-5053 Dec Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Ridgeley 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 300 26753 USA 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2] No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 maintenance worker orker Kelly Spring Tire Co 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Raymond Edward Hershberger Florence Utterback 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Teresa Hershberger/spouse P.O. Box 300 Ridgeley, WV 26753 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Warie, Director 22. Name and Address of Fecility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTRAOPERATIVE Due to (or as a consequence of): CORONARY ARTERY DISEASE Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): MYOCARDIAL Due to (or as e consequence of) MAMMARY GRAFT DISSECTION 4116 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 28b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4□ Nursing Home 5□ Residence 6□Other (Specify) 27. Manner of Death 28e. Dete of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending ADRTA TEAR AFTER CANNULATION 1 Yes 2 No 25 M investigation 5/2006 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 900 SE TOW DRIVE

/Medical Examiner The law requires that the death certificate be executed Attending Physician:

**Physician** 

/Medical

Examiner

Director

Funeral

۵

Completed

Be

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

edicai

Funeral

Director

5.1 and 2 should be filed within 72 hours after death with the Maryland Heelth and Mental Hygiene.
1. Is marked other than \*natural; or Hems 23a or 28a-f show

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Madical Examiner must be notified at

Physician

ettending physicien end I for use es the buriel-trensit Division of Vital Records, P.O. Box 68760 been signed by the e should be detached s certificate has b director, page 2 s funerel director, To the Hospital or A within 24 hours efter To the Funeral Direct completely filled in by

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide HUSPITAL 29a. Certifier 29b. Signature end title of certifier

SETON

29c. License number

CHIMBERLAND MD 21502

Tertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

30. Neme end eddress of person who completed cause of deeth (item 23a) (Type, Print)

D0061982

CHIMBERLAND, MD

29d. Date signed (Month, Day, Year) 2006

State Registrar 31. Dete filed (Month, Day, Year) 2 0 2006

902

DRIVE SUITE 32. Registrer's Signature

ORIGINAL

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

|  | •              | State Registrar  |   | ,                            | Certif                     | icate of                                   | Death   |                          | Re                                       | g. N6                  | 006                                       | 2273   |
|--|----------------|--|---|------------------------------|----------------------------|--|---|--------------------------|--|------------------------|---|--|
| Physici  | an             | 1. Decedent's Name (First, Middle, L.  | •   |                              |                            |  |   |                          | Date of Deat<br>Month                    | . Day                  | Year                                      | 3. Time of Deat                                      |
| /Medic   |                |  | Dixon Hat   | теу                          |                            | O1 T                                       | . Landing of D                                  |                          | uly:                                     | 16,                    | 2006<br>ounty of Death                    | 5:37 F   |
| Examin   | er             | 4a. Facility Name (If not institution, gi<br>Laurel Regiona  | al Hospita  |                              |                            | Lai  | r Location of D                                 |                          |  | Pri                    | ince C                                    | george's   |
| Funeral<br>Director  |                | 240-98-2547  | Sex 7. Age  | (In yrs. last bi             |                            | onths Days                                 | ff Under 24 I<br>Hours N                        | din.                     | Date of Birth<br>Month, Day,<br>Tune 1,1 | Year)                  |   | nplace (State or Fore<br>untry)<br>Hanover Co,       |
| and w  |                | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, Tow               | m or Locat                 | on   |   |                          |  |                        |   | 10d. Inside City Lin                                 |
| Ba-f eho   | Director       | NC Cumber  | 1and  |                              |                            |  | ttevil1   | le                       |  |                        |   | 1 □ Yes 2 🔀  |
| th with th   | al Dire        | 10e. Street and Number<br>2603 Venice Co   | urt   |                              |                            | 10f. Zip Code<br>28306                     | 5   |                          | 1  | _                      | n of What Cou<br>JSA                      | untry?   |
| d within 72 hours after death with the Maryland<br>Jene.<br>Ir then "naturel", or iteme 23a or 28e-f ehow<br>I're Medical Evantine meet be notified at             | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Decedent Ev<br>Armed Forces?<br>1 ZYes 2 ☐ No<br>If Yes, Give<br>Year or Dates: |                              |                            | Decedent of Fes, specify Cub.              | dispanic Origin'<br>an, Mexican, Pi<br>Specify: | ? (Specify<br>uerto Rica | Yes or No-<br>in, etc.)                  |                        | Race - Amer<br>Black, White<br>pecify: Wh |  |
| 72 hou<br>natura<br>lical E  | ted            | 15. Decedent's E<br>(Specify only highest g  | Education   | 16a                          | . Deceden                  | 's Usual Occup                             | pation<br>during most of                        | working                  |  | 16b. Kind              | of Business/l                             | ndustry  |
| within<br>ene.<br>then   | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5+   | )                            | life. DO                   | NOT use retire.<br>Surveyo                 | d)  | g                        |  | I                      | and                                       |  |
| be file<br>id othe<br>event,   | To Be C        | 17. Father's Name (First, Middle, Las<br>Charles Hatley  | st)   |                              |                            |  | 18. Mother's                                    | Name (Fii<br>Orrai       |  | Maiden Si<br>188e]     |   |  |
| s t and 2 should<br>! Health and Mer<br>tem 27 ie merke<br>other treumetic   |                | 19a. Informant's Name/Relationship Loa S. Hatley   | (Type, Print)   | 190                          | •                          | ,  | and Number of                                   |                          |  |                        |   |  |
|  |                | 20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control o |   |                              | ry, cremat                 | on (Name of<br>ory or other pla<br>remator | <sup>сө)</sup> Ji<br>Y 2                        | 11y 1<br>2006            | 9,                                       |                        | ition - City or 1                         |  |
| permit. Page<br>Department of<br>Important: If<br>eny Injury or<br>once.   |                | 21. Signature of Funeral Service Lice  | ensee   |                              | 22. N                      | one and Address 1501 Fas                   | ss of Facility<br>L. Stever<br>t Fort Ax        | ns Fun<br>ve. Ba         | eral Ho<br>1timore                       | me In                  | ī230                                      |  |
| *  |                | 23a. Part1. Enter the disease, or co-<br>shock, or heart failure. List on  |   |                              | not enter t                | ne mode of dyll                            | ng, such as car                                 | rdiac or re              | spiratory arre                           |                        |   | Approximate<br>Interval Between<br>Onset and Death   |
| Physician /Medical   |                | Immediate Cause (Final disease or condition resulting in death)  | a. Due to (or as a  |                              |                            | INT  | iercti  | 0,0                      |  |                        |   |  |
| Examiner   |                | 1  |   | ser7                         | · ·                        | 00   |   |                          |  |                        |   | > 1 yea  |
| ν #  | Iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Due to (or as a   |                              |                            |  |   |                          |  |                        |   | 1  |
| and and  | Examiner       | that initiated events resulting in death) Last   | c<br>Due to (or as a  | consequence                  | of):                       |  |   |                          |  |                        |   |  |
| icate be executed<br>physician and<br>s the burial-transit   |                |  | d   |                              |                            |  |   |                          |  |                        |   |  |
| ertifica<br>ding ph  | Medical        | IF FEMALE:   | 00- #   | 4                            |                            | _  |   |                          |  |                        |   |  |
| The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be detached for use es the burial-transit | Physician/     | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown   | 23c. ff yes, outcome o  1 Live birth 2  4 Pregnant at ti 9 Unknown                      | Fetal deat                   |                            | topic pregnanc<br>ther (specify) _         | у   |                          |  | 23                     | d. Date of deli<br>Month                  | very<br>Day Year                                     |
| res that tigned by   | by Ph          | Part II. Other significant conditions  | contributing to death but   | t not resulting              | in the unde                | rtying cause gr                            | ven in Part I.                                  |                          | 23e. Did tol                             | bacco use              | contribute to                             | the cause of death                                   |
| w require<br>been sig<br>should b  | ted t          |  |   |                              |                            |  |   |                          | 1 <b>\S</b> Y                            | es 2 🗆                 | No 3□Pro                                  | obabfy 4 □Unkno                                      |
| The taw rate has be page 2 sh  | Completed      |  |   |                              |                            |  |   |                          | 24a. Was a autops perform                | Sy                     | prior to death?                           | topsy findings availa<br>completion of cause<br>2 No |
| Physician: Th<br>this certificate<br>ral director, pag   | Be             | 25. Was case referred to medical examiner?   | Hoenital:   |                              |                            | . 04                                       | 26. Place of                                    | Death (C                 | heck only on                             | 10)                    |   |  |
| d is   | 2<br>2         | 1 ☐ Yes 2 ☑ No 27. Manner of Death   | Hospital: 1 Inpatien  |                              | Utpatient<br>Time of       | 30 DOA                                     |   |                          | 5 Reside                                 |                        | Other (Spec                               | cify)  |
| nding<br>tth.<br>: After<br>e funer  | atlon          | 1 Naturaf 5 Pending 2 Accident investigat  | 28a. Date of Injury<br>(Month, Day  | Year)                        | fnjury                     | 28c. fnju<br>Wo<br>M                       | rk?<br>]Yes 2 ☐ No                              | ,                        | . Describe in                            | ow injury              | occurred                                  |  |
| To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After the   | Certification: | 3 Suicide 6 Could not determine  |   | ry - At home, (<br>(Specify) | farm, stree                | , factory, office                          |   | 281.                     | Location (SI<br>City or Town             | treet and<br>n, State) | Number or Ru                              | ral Route Number,                                    |
| To the Hospitel within 24 hours a To the Funeral Completely filled   | edical (       | 29a. Certifier 1 Certifying (Check only 2 Medical Ex   | Physician: To the best of aminer: On the basis of and manner state                      | examination a                | ge, death o<br>nd/or inves | ccurred at the ti                          | me, date and popinion, death of                 | occurred a               | due to the cat the time, d               | ause(s) a<br>ate and p | nd manner as<br>lace, and due             | stated.<br>to the cause(s)                           |
| To th<br>To th<br>compl  | Me             | 29b. Signature and title of certifier  | Susa  | مر                           |                            | 29c. Licen                                 | se number                                       | 3                        | 2  |                        | signed (Monti                             |  |
| 8  |                | 30. Name and address of person wh  | 2 SWAY  | to he                        | 000                        | MIC  | helevi  | Me                       | Rd                                       | 54                     | Bifzz                                     | Bowie M  |
|  | ate            | 31. Date filed (Month, Day, Year)  | 32. R distra  |                              | . 1.                       | nle  |   |                          |  |                        |   |  |
| Regist   | Accep          | JUL 2 0  | ZUUO SURLU  | w B.                         | 19                         |  | <del></del>                                     |                          |  |                        |   |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:50AM hobert 18 2006 TUL ZIVIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ST. AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 217-26-9972 Yrs. Director 1931 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Ma by Funeral Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 USA 3907 owes to N death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced "neture!" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Norman ruck Driver 11th injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked oth any liqury or other traumatic event any liqury or other traumatic event ans. 17. Father's Name (First, Middle, Last) JONES Thomas avinia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd wife Baltimore 3907 Flowerton MO atrina DONE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition † Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 24/06 Arbubus Cemebery 21. Signature of Funeral Service Consee 22. Name and Address & Facility hatman-Harris FUNLTAL HON 5240 Reisters town Rd Baltimore Ad 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Finat disease or condition resulting in death) LUNG CANCER **Physician** YEARS /Medical Due to (or as a consequence of): Examiner UNKNOWN PNEUMONTA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Medical Certification; To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 2□ No certificate 1 Yes 212No 1 Yes Division of Vital To the Hospitel or Attending Physicien: within 24 hours effer death.

To the Funerel Director: Affer this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 2 No Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Othturaf 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide TIME Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) P18616 JULY 18 3

Registrar

DHMH 17 Rev 1/2001

900 SCATON AVENUE, BALTIMORE, MD-21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

PRIYANKA NELLORI

JUL 2 0 2006

31. Date fifed (Month, Day, Year)

|  |                   | riease   | Otet of Manual                                    |                     |                     |   | •                         | -                                    |   |
|--|-------------------|--|---|---------------------|---------------------|---|---------------------------|--------------------------------------|---|
|  |                   | 1 _ For<br>State   | State of Maryla                                   | -                   |                     |   | ental Hygi                | ene                                  | 00700   |
|  |                   | Registrar  |   | Cen                 | tificate of         |   |                           | g. No. /                             | 22/38   |
| Physici  |                   | 1. Decedent's Name (First, Middle, Las<br>Linda K. J   | ,   |                     |                     |   | 2. Date of Death<br>Month | Day Year                             | 3. Time of Death                              |
| /Medic   |                   | 4a. Facifity Name (If not institution, give  |   |                     | 4h City Town o      | or Location of Death                        |                           | 4c. County of Death                  | 11  |
| Examir   | ier               | 4  |   |                     | Decor is            | - L   |                           | 2                                    |   |
|  |                   | FRANKLIN S<br>5. Social Security Number 6. S   | THATE TO  | ontal               | If Under 1 Year     | If Under 24 Hrs.                            | 8. Date of Birth          | 9 Birth                              | DORE  |
| Funeral<br>Director  |                   |  | TH OFF  | 57 Yrs.             | Months Days         | Hours Min.                                  | Month, Day, Dec. 14,      | 1948 NC                              | intry)  |
|  |                   | Usual Residence of Decedent  |   | <i>31</i>           |                     | <u> </u>                                    | Jec. 14,                  | 1340 NC                              |   |
| yland  |                   | 10a. State 10b. County   |   | City, Town or Loc   | ation               |   |                           |                                      | 10d. Inside City Limits                       |
| e Mar  | ctor              | MD Balti   | more  | Mid                 | ldle Ri             | ver   |                           |                                      | 1 ☐ Yes 2X No                                 |
| O036 hours after death with the Maryland turet', or flame 23e or 28e-1 show at Examinar must be notified at  | Funeral Director  | 10e. Street and Number 12 Slipstream   | Court   |                     | 10f. Zip Code       | 1220  | 10                        | g. Citizen of What Cou<br>USA        | intry?  |
| de de de de de de de de de de de de de d   | Jera              | 11. Marital Status   | 12. Was Decedent Ever in                          | 1 U.S. 13. W        | as Decedent of H    | Hispanic Origin? (Specan, Mexican, Puerto F | cify Yes or No-           | 14. Race - Ameri                     |   |
| or the   | F                 | 1 Never Married 2 Married  | Armed Forces?<br>1 ☐ Yes 2€250                    |                     |                     |   | lican, etc.)              | Black, White                         |   |
| 33   | þ                 | 3X Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:                    | 1                   | ☐ Yes 2 🗓 No        | Specity:                                    |                           | Specify: Wh                          | ıte   |
|  | Completed         | 15. Decedent's Ed<br>(Specify only highest gra   | lucation  | 16a. Decede         | ent's Usual Occup   | pation                                      | 1                         | 6b. Kind of Business/Ir              | ndustry                                       |
| within 72 within 72 sere.  | ğ                 | Elementary/Secondary (0-12)  | Colfege (1-4or 5+)                                |                     |                     | during most of workin<br>d)                 | 9                         |                                      |   |
| _ O = 5 = -  | Ş                 | 12th   |   | Hom                 | emaker              |   |                           | own home                             |   |
| Ind 2  | Be                | 17. Father's Name (First, Middle, Last)  |   |                     |                     | 18. Mother's Name                           |                           |                                      |   |
|  | 2                 | Joseph Medvid  | ovich   |                     |                     | Martha                                      | Glance                    | <b>!</b>                             |   |
| and and and and and and and and and and  |                   | 19a. Informant's Name/Relationship (   | •           |                     |                     |   |                           | City or Town, State, Zi              | ip Code)<br>21220                             |
| B, N   | 0.8               | John Jackson l   |   | D. Place of Dispos  |                     | eam Court                                   |                           |                                      |   |
| 0 0 0  |                   | 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐  | Removal from State                                | cemetery, crem.     | atory or other plac | ce)   | 11 / 0 6 B                | Oc. Location - City or T<br>altimore | own, State                                    |
| Baltimor<br>semit. Pages<br>Department of II<br>mportant: If Its<br>any Injury or o  | 1 3               | 4 ☐ Donation 5 ☐ Other (Specify  | ,   |                     |                     | 1   | 21/06 5                   | arcimore                             | FID   |
| Baltimo permit. Page Department of Important: If any Injury or   |                   | 21. Signature of Funeral Service Licen   | 1 Connel  | // //               | Name and Addre      | 300   | Mace                      | Ave. Balt                            | to. MD  |
|  |                   | 23a. Part1. Enter the disease, or companies shock, or heart failure. List only                             | lications that caused the d                       | eath. Do not ente   | r the mode of dyir  | runeral<br>ng, such as cardiac or           | respiratory arres         | of Essex                             | Approximate                                   |
| PO E   |                   | shock, or heart failure. List only   |   | D . 25 F            | ,                   | 1   |                           |                                      | Interval Between<br>Onset and Death           |
| Pnysician<br>/Medical  |                   | disease or condition resulting in death)   | a   | 1                   | m                   | and +                                       |                           |                                      | muntes  |
| Examiner   |                   |  | Due to (or as a cons                              | sequence of):       | orter               | a direc                                     | 2 6                       |                                      | 11-51   |
|  | 2                 | Sequentially list conditions,  | Due to (or as a cons                              | sequence off:       | ~ , ,               | 1 000                                       | 10                        |                                      | years   |
| De is  | Examiner          | Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 545 (5) 45 4 50115                                | 30420/100 01).      |                     |   |                           |                                      |   |
| xecur<br>and   | xar               | that initiated events resulting in death) Last   | C Due to (or as a cons                            | sequence of):       |                     |   |                           |                                      |   |
| 760,<br>te be el<br>ysicien  | calE              |  | (   |                     |                     |   |                           |                                      |   |
| cate<br>phys   |                   |  | . d   |                     |                     |   |                           |                                      |   |
| Box 68 eath certifical attending phy   | /Me               | IF FEMALE:   | 23c. If yes, outcome of pre-                      | ana nav             |                     |   |                           |                                      |   |
| BO ath c   | lan               | 23b. Was decedent pregnant in the past 12 months?  | 1 Live birth 2 ☐ F                                | etal death 3 1      | Ectopic pregnancy   | y   |                           | 23d. Date of deliv<br>Month          | rery<br>Day Year                              |
| O er ghe hed hed hed hed hed hed hed hed hed h   | by Physician/Medi | 1 ☐ Yes 2 ☑tNo<br>9 ☐ Unknown  | 4□Pregnant at time o<br>9□Unknown                 | ordeath 5∐          | Other (specify)     |   |                           |                                      | ,   |
| P. hat til   | 문                 | Part If. Other significant conditions o  | ontributing to death but not                      | resulting in the un | deriving cause giv  | ven in Part I                               | 23e Did toba              | cco use contribute to t              | the cause of death?                           |
| cords, P w requires that s been signed b   | g                 | Dister   | Mellits   | TINL                | Ti                  | on with diet.                               |                           | ,                                    | bably 4 Unknown                               |
| requision is   | ete               | Ceal Class   | . 1/0   | 1                   |                     |   | -                         |                                      |   |
| e law  | Completed         | CARA STR   | e kidny   | Dijery.             |                     |   | 24a. Was an autopsy       | prior to co                          | opsy findings available ompletion of cause of |
| T. Th  | S                 |  |   |                     |                     |   | performe<br>1  Yes 2      | ed? death?<br>No 1 ☐ Yes             | 2/2No   |
| /ita   | Be                | 25. Was case referred to medical examiner?   | Hospital:   |                     | 1 04                | 26. Place of Death                          |                           |                                      |   |
| ohysi<br>this c  | ဥ                 | 1 ☐ Yes 2 No   | 1 L Inpatient 2                                   | ER/Outpatient       |                     | 4 🗆 Nursing Hom                             |                           | ce 6 ☐ Other (Special                | fy)   |
| ing P  | on                | 27. Manner of Death 1 Natural 5 ☐ Pending  | 28a. Date of fnjury<br>(Month, Day Year           | 28b. Time of Injury | 28c. Injur<br>Wor   |   | 3d. Describe how          | infury occurred                      |   |
| SiC<br>Sicath<br>Geath<br>tor:<br>the  | icat              | 2 Accident investigation 3 Suicide 6 Could not be  |   | 1 hama (a           |                     | Yes 2 □ No                                  | 26 1 (2)                  |                                      |   |
| Division of Vital Records, P.O. to Attending Physician: The law requires that the dafter death. Director: After this certificate has been signed by the fin by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached   | Certification:    | 4 Homicide determined  | 28e. Pface of Injury - A<br>building, etc. (Spe   | ecify)              | et, factory, office | 21  | City or Town,             | et and Number or Rur<br>State)       | al Houle Number,                              |
| spita<br>ours<br>neral   |                   | 29a. Certifier 1 Certifying Pb   | ysician: To the best of my                        | knowledge, death    | occurred at the tir | me, date and place, ar                      | nd due to the cau         | se(s) and manner as s                | stated  |
| Division of Vital Records, P.O. Box 68760, To the Hospitat or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | edical            | (Check only 2 Medical Exam   | niner: On the basis of exam<br>and manner stated. | ination and/or inve | estigation, in my o | ppinion, death occurred                     | d at the time, dat        | e and place, and due to              | o the cause(s)                                |
| To tl<br>within<br>To tl   | ž                 | 29b. Signature and title of certifier  | 1   |                     | 29c. Licens         | -   | 290                       | d. Date signed (Month,               | Day, Year)                                    |
|  |                   |  |   |                     | ()                  | 34531                                       |                           | 7/19/                                | 06  |
| 1-   |                   | 30. Name and address of person who   | completed cause of death (I                       | tem 23a) (Type, P   | rint)               |   |                           |                                      |   |
| 9  |                   | DR. ann more   | U 9000  | Frank               | lin squ             | ace de                                      | Baltin                    | ORE, MD                              | 21237   |
|  | ite               | 31. Date filed (Month, Day, Year)  JUL 2 0   | 32. Redistrar's Sig                               | gnature             | back .              |   |                           | ,                                    |   |
| Regist   | air               | JUL Z U  | LUUU PILIPELIA                                    | 1 55 19             |                     |   |                           |                                      |   |

Jeremy C. Jennings

Please Type or Print in Black Indelible Ink

**UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Amend #20b Per FH C857 7926/68te of Death Reg. No 2. Date of Death Physician/ 3. Time of Death Month Day July 13, 2006 **Medical Examiner** DENNINGS 1729 hrs JEREMY COREY 4a Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 1118 Argyle Avenue Baltimore NIA 5. Social Security Number If Under 1 Year | If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign Hours Director 24.13.4566 20 1 X M 2 02 - 13 - 1986 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 1 K Yes 2 No 28a-f show NIA BALTIMORE MD permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygien. Department of Health and Mental Hygien. In portant: (If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once, injury or other tranmatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country AVENUE 21223 USA 1118 ARGLE 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White, etc. 2 Married Never Married 2 1 No Yes 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: BLACK ģ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 LABORER CONSTRUCTION GRADE N 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Mai Be MEREDITH JENNING8 CENTRAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JENNINGS RD. CENTRAL WINDER WINDSOR MILL MD. 21244 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 1 K Burial 2 Cremation 3 BALTIMORE, MD MT. ZION Donation 5 Other Specify Ignature of Funeral Service Licensee

22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NATL. PIKE BALTO. MD 21229

Part I Eyler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death Gunshot wounds (2) to the head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last olli To the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Live hirth Fetal death 3 Ectopic pregnancy Month Year Day Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ≥ 1 Yes 2 V No 3 Probably 4 Unknown Completed has been si 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? page ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Be Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene After this ပ 1 🗸 Yes 2 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: within 24 hours after co...
To the Funeral Director: A Subject shot **FOUND** Natural 5 Pending 1 Yes 2 V No Jul 13, 2006 1720 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town State determined (Specify) Vacant Building 1118 Argyle Avenue, Baltimore, MD 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 14, 2006 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

|   | 1 - For<br>State Amend #19b  | State of Maryland / Deper FH g858 8/01/   | epartment of Health and<br>Pertificate of Death  | Mental Hygier  | 211116   | 22740  |
|---|--|---|--|--|--|--|
| Physiciar<br>/Medica  |  | Jackson   |  |  | Oay Yeer   | 3. Time of Death 4:00 PM                     |
| Examine   | 4a. Facility Name (If not institution, give  | RRACE   | 4b. City, Town, or Location of Dea  BATTMORE  Tayl If Under 1 Year   If Under 24 Hrs                             |  | 4c. County of Death                                      | (Cr  |
| Funeral<br>Director   | 241 · 50 · 1315 Usual Residence of Decedent  | 20 F 70 Yr  | Months Days Hours Min  |  | 36 Coun  | lace (State or Foreign ltry)                 |
| death with the Maryland me 23a or 28a-f show treast by notified at  | 10a. State 10b. County  MD NA  10e. Street and Number  | BALTIMO   | ORE  |  |  | 0d. Inside City Limits 1 XYes 2 No           |
| 3a or 2   | 200. Street and Number   | ZRACE   | 10f. Zip Code 21216  | 10g.   | Citizen of What Coun                                     | try?   |
| urs after   | 11. Marital Status  1 Never Married 2 (2) Married  3 Widowed 4 Divorced  | 12. Was Decedent Ever in U.S.<br>Armed Forces?<br>1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1   | 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ( No Specify:             | to Rican, etc.)                                      | 14. Race - America<br>Black, White, e<br>Specify: BLAC   | etc.<br>OK                                   |
| withir then   | 15. Decedent's E<br>(Specify only highest gr.<br>Elementary/Secondary (0-12)   | College (1-4or 5+)  | ecedent's Usual Occupation Silve kind of work done during most of wo te. DO NOT use retired) LECTRICIAN          | rking  | ME IMPR  | ·  |
| De da out   | 17. Father's Name (First, Middle, Last   |   | AUCE T   | me (First, Middle, Maid<br>XVIS                      |  |  |
| ore, Maryia<br>s 1 and 2 should<br>of Health and Men<br>tiem 27 is marks<br>other traumatic   | 19a. Informant's Name/Relationship ( SEPRENA JACKS) 20a. Method of Disposition   | ON (DAUGHTER) 1/10  | isposition (Name of  | IKE #TT S  | y or Town, State, Zip  ILVER SPRI  Location - City or To | NG, MD                                       |
| Page<br>Page<br>ment o<br>ant: if<br>ury or   | 1 MB Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Line)   | Removal from State GARRISO  | N FOREST 01.2  | 26.06 ON   | IINGS MILL   | 100  |
| Demit. Dependit. Import Import any inj  | Danghon Cl   | plications that caused the death. Do not  | 22. Name and Address of Facility VAUGHN C GREENE FU 5151 BAUO. NATU PIKE enter the mode of dying, such as cardia | . BAUTO. MC  | 21229  | Approximate<br>Interval Between              |
| Physician<br>/Medical<br>Examiner   | Immediate Cause (Final disease or condition resulting in death)  | a. Oronary  Due to (or as a consequence of)   | atherosclero<br>Mellitus, typ  | 515  |  | Onset and Death  years                       |
| 5 100   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of)   |  | e  |  | yeurs  |
| ate be shysicie the bur   |  | Due to (or as a consequence of) d   |  |  |  |  |
| vicien: The law requires that the death certific certificate has been signed by the attending practor, page 2 should be detached for use as   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | 23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown   | 3 ☐ Ectopic pregnancy<br>5 ☐ Other (specify)   |  | 23d. Date of deliver<br>Month                            | ry<br>Day Year                               |
| wrequires that the been signed by th should be detache  | Part II. Other significant conditions  | contributing to death but not resulting in th   | ne underlying cause given in Part I.   | 23e. Did tobacc                                      | o use contribute to the                                  | e cause of death?                            |
| The law reco  |  |   |  | 24a. Was an autopsy performed 1 Yes 2                | prior to com<br>death?                                   | osy findings available inpletion of cause of |
| VICATION CONTINUES INSCRIPTION DE CONTINUE INSCRIPTION DE CONTINUES INSCRIPTION DE CONTINUES INSCRIPTION DE CONTINUES INSCRIPTION DE CONTINUES INSCRIPTION DE CONTINUES INSCRIPTION DE CONTINUES INSCRIPTION DE CONTINUES INSCRIPTION DE CONTINUE | 25. Was case referred to medical examiner?   | Hospital:   | Other  | ath (Check only one)                                 |  |  |
|   | -  | 1 ☐ Inpatient 2 ☐ ER/Outpater  28a. Date of Injury (Month, Day Year)  1 ☐ Inpatient 2 ☐ ER/Outpater  28b. Time Injury 1 ☐ Inpatient 2 ☐ ER/Outpater  28b. Time 1 ☐ Inpatient 2 ☐ ER/Outpater  28b. Time 1 ☐ Inpatient 2 ☐ ER/Outpater  28b. Time 28b. | ne of 28c. Injury at   | 28d. Describe how in                                 | 6 ☐Other (Specify, jury occurred                         | )  |
| DIVISION  tel or Attending s after death. el Director: Attene ed in by the fune   | 27. Manner of Death    Natural   5   Pending   2   Accident   Investigation   3   Suicide   6   Could not be determined   4   Homicide   determined        |   | , street, factory, office  | 28f. Location (Street<br>City or Town, Sta           | and Number or Rural<br>ate)                              | Route Number,                                |
| he Hospii<br>in 24 hour<br>he Funer<br>pletely filk   | 29a. Certifier Check only one)  29a. Certifying Pl 2 Medical Example one)  | sysician: To the best of my knowledge, on the basis of examination and/or and manner stated.  | death occurred at the time, date and place<br>or investigation, in my opinion, death occurrence                  | e, and due to the cause<br>urred at the time, date a | (s) and manner as sta<br>and place, and due to           | ited.<br>the cause(s)                        |
| To t<br>To t  | 29b. Signature and hite of certifier   | 4   | 29c. License number  | 29d. 0   | Date signed (Month, D                                    | lay, Year)                                   |
| .0  | 30. Name and address of person who   | completed cause of death (Item 23a) (Ty   | D5/0(8   | /  | 118/06   |  |
| 10  | Douglas Pinto  | , MD 3421 B   | enson Ave. sur   | Je 230, B  | altimore   | MO 21227                                     |
| State<br>Registra   | 1000 3 0 5   | 32. Finistrar's Signature   | Rose   |  |  |  |

|         |   |                | 1 - For<br>State<br>Registrar  | State of Maryland  |  | nt of Health and I<br>te of Death                                      |  | ne<br>No.2006  | 22741   |
|---------|---|----------------|--|--|--|--|--|--|---|
|         | Physici<br>/Medi  |                | 1. Decedent's Name (First, Middle, Last)   | w. Jac   | Kson   |  | 2. Date of Death<br>Month<br>July                | Day Year   | 3. Time of Death 6 11:55 A M                    |
|         | Examir  |                | 0, .,0   | lospital   |  | Baltimor  1 Year   If Under 24 Hrs.                                    | و  | 4c. County of Deatl  | NIA   |
|         | Funeral<br>Director   |                | 5. Social Security Number 6. Sex 24f 74-1364 19  Usual Residence of Decedent   | M 2 F 7. Age (In yrs. last   | Yrs. Months  |  | 8. Date of Birth<br>Month, Day, Ye               | 142 Sou  | hplace (State or Foreign untry)  The Carolina   |
|         | e Marylanc<br>ia-f show   | ctor           | 10a. State 10b. County   | 10c. City, T   | own or Location  | iltimor  | e  |  | 10d. Inside City Limits 1 Xes 2 □ No            |
|         | ath with the Maryla<br>23s or 28s-f shot  | rai Director   | 102  | jewood &   | 4.   | ip Code<br>2,229   | Ţ  | Citizen of What Co   | A   |
|         | 036<br>urs after dea<br>al', or Iteme   | by Funerai I   | 11. Marital Status  1 Never Married 2 Marned  3 Widowed 4 Divorced   | 2. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 DNo II Yes, Give Year or Dates:                            | 13. Was Dec  | edent of Hispanic Origin? (Secify Cuban, Mexican, Puert 22 No Specify: | pecify Yes or No-<br>o Rican, etc.)              | 14. Race - Amer<br>Black, White<br>Specify:  |   |
|         | d 21215-0036<br>filed within 72 hours after death with the Maryland<br>Hygiene.<br>wher than "natural", or Iteme 23a or 28a-f show<br>int, the Medical Exeminat must be maillised at  | Completed      | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)  | cation 1 completed) College (1-4or 5+)   | life. DO NOT   | ork done during most of wor  |  | Kind of Business/  | ndustry<br>2 m                                  |
|         | E Sab   | To Be Co       | 17. Father's Name (First, Middle, Last)  | Jacks  |  |  | ne (First, Middle, Main                          | den Sumame) I 1 e  | Res   |
|         | 2 8 8 8 5 E   | -              | 19a. Informant's Name/Relationship (Typ) Hazel Jackson   | pe, Print)   |  | ewod St. E   | iral Route Number, Ci                            | 4  | 1p Code)<br>229                                 |
|         |   |                | 20a. Method of Disposition  1. Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)  | emoval from State  | e of Disposition (Ni<br>etery, crematory or<br>don Par | other place)<br>R Cem. 7-2   | 4-66 30  | E. Location - City or The City or The Country of th | e, md.  |
|         | Baltimo   |                | 21. Signatur of Juneral Service License  23a. Part1. Enter the disease, or compli  | hand   | Gan  |  | uneral H   |  | o, nd, 21229 Approximate                        |
|         | Physician<br>/Medical   |                | shock, or heart failure. List only on<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)   | e cause on each line.  Hypoxic  Due to (or as a consequer  | Ence   | phalopath  |  |  | Interval Between<br>Onset and Death             |
| 3       | Examiner  De executed price and price and price and price and price and price and price are also and price are also and price are also and price are also and price are also and price are also | licai Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequer  Due to (or as a consequer  Due to (or as a consequer                                | Myocar   | dial inf   | Parction   |  | 3 days  |
| harles  | I Records, P.O. Box 687 The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 3c. If yes, outcome of pregnancy<br>1 ☐ Live birth 2 ☐ Fetal de<br>4 ☐ Pregnant at time of deat<br>9 ☐ Unknown | ath 3 Ectopic  |  |  | 23d. Date of deliment  | very<br>Day Year                                |
| Ch      | ds, P.( uires that the signed by id be detac  | by             | Part II. Other significant conditions con History of a   | tributing to death but not resulting   |  | cause given in Part I.   |  | ,  | the cause of death?                             |
| ,<br>no | of Vital Records, Physician: The law requires i   | Completed      | Systemic Hy  |  |  |  | 24a. Was an<br>autopsy<br>performed              | prior to c<br>death?   | topsy lindings available completion of cause of |
| ackson  | on of Vital Reding Physician: The In. After this certificate he funeral director, page  | Be             | 25. Was case referred to medical examiner?   |  |  |  | 1 ☐ Yes 2 ☑<br>ath Check only one                |  |   |
| ac      |   | . To           | 1 ☐ Yes 2 ☑ No  27. Manner of Death  | ospital: 1 Inpatient 2 ☐ ER 28a. Date of Injury 28   | VOutpatient 3 0 E                                      |  | lome 5 Residence                                 |  | erfy)   |
| n       | Division (To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral  | Certification: | 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined  | 28a. Date of Injury<br>(Month, Day Year) 28<br>28e. Place of Injury - At home<br>building, etc. (Specify)      | Injury<br>M<br>e, farm, street, lacto                  | 28c. Injury at Work? 1 Yes 2 No  |  | t and Number or Ru   | ral Route Number,                               |
|         | s Hospital<br>24 hours<br>e Funeral<br>letely fiiled  | Medicai Co     | (Check only 2 Medical Examir<br>one)   | sician: To the best of my knowle<br>ner: On the basis of examination<br>and manner stated.                     | n and/or investigation                                 | n, in my opinion, death occu   | , and due to the cause<br>rred at the time, date | e(s) and manner as<br>and place, and due   | stated.<br>to the cause(s)                      |
|         | To th<br>within<br>To th<br>compl   | Me             | 29b. Signature and title of certifler  Paraston Fall   | eli, medical r   | resident <sup>2</sup>                                  | OP1951   |  | Date signed (Month   |   |
|         | 5   |                | 30. Name and address of person who co<br>Parasto . Fazel;  | , St. Agn  | es Hosp  | ital 900 S   | .Caton Av  | e Balt   | , 2006<br>21229<br>imore, MD                    |
|         | St  | ate            | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signatur   | to Rocal   | 9 8  |  |  |   |

|                     |  |                | For<br>State<br>Registrar   | State of N                     | Marylan                              | •                              | artment of H<br>tificate of I              |               |             | F   | Reg. No.  | 006                                 | 22742   |  |
|---------------------|--|----------------|---|--------------------------------|--------------------------------------|--------------------------------|--|---------------|-------------|---|---|-------------------------------------|---|--|
|                     | Physici<br>/Medic  |                | 1. Decedent's Name (First, Middle, Last)  | Ioan Ko                        | ovacs                                |                                |  |               |             | 2. Date of Dea<br>Month<br>July           | Day<br>15   | Year<br>2006                        | 3. Time of Death 10:15 A.M                      |  |
| >                   | Examir   |                | 4a. Facility Name (If not institution, give str   | eet and numbe                  | r)                                   |                                | 4b. City, Town, or                         |               |             |   | 4c. Co  | unty of Death                       |   |  |
|                     |  |                | 924 Andrews Road  5. Social Security Number 6. Sex  | 17.                            | Nan /la um                           | (not birthday)                 | Glen I                                     | Burnie        |             | 9. Onto of Bird                           | Anne Arundel  |                                     |   |  |
|                     | Funeral<br>Director  |                |   | 1 2□F /.′                      | 60                                   | last birthday)<br>Yrs.         | Months Days                                | Hours         | Min.        | 8. Date of Birt<br>(Month, Day<br>April 1 | 9. Birthplace (State or Foreign<br>8, 1946 Romainia |                                     |   |  |
|                     | _  |                | Usual Residence of Decedent   |                                |                                      |                                |  |               |             | TPT I                                     | 0, 17   |                                     |   |  |
|                     | arylar<br>ehow   | ٦              | 10a. State 10b. County  | J_7                            |                                      | y, Town or Lo                  |  |               |             |   |   |                                     | 10d. Inside City Limits 1 ☐ Yes 24☐ No          |  |
|                     | the M  | Director       | Maryland Anne Arur  | idel                           | G                                    | len Bu                         | rnie<br>10f. Zip Code                      |               |             |   | 10a Citizen   | of What Cou                         |   |  |
|                     | With With  |                | 924 Andrews Road  |                                |                                      |                                | 210  | 60            |             |   | U.S   |                                     | ·····y ·  |  |
|                     | death  | Funerai        | 11. Marital Status  | . Was Deceder<br>Armed Forces  | nt Ever in U                         | .S. 13. V                      | Was Decedent of Hi<br>Yes, specify Cuba    |               | gin? (Spec  | offy Yes or No-                           | 14.   | Race - Americ                       |   |  |
| 98                  | 72 hours after death with the Maryland<br>Inaturel; or Iteme 23e or 28e-f ehow<br>disal Examiner munt be nutified at   |                | 1 X Never Married 2 ☐ Married   | 1 ☐ Yes 2X<br>If Yes, Give     | No                                   |                                |  | Specify:      | , rueno r   | ticari, etc.)                             | 1   | Black, White,<br>ec <i>ify:</i> Whi |   |  |
| Ö                   | 72 hours<br>naturel',  | ed by          | 3 Widowed 4 Divorced  | Year or Dates                  | 5:                                   | 162 Decer                      | lent's Usual Occupa                        | ation         |             |   |   | of Business/In                      |   |  |
| 15                  | n na   | Completed      | (Specify only highest grade Elementary/Secondary (0-12)   |                                | · 6.1                                | (Give                          | kind of work done of<br>OO NOT use retired | during most   | t of workin | g   | TOD. KING C   | , Dusinosa, in                      | oustry  |  |
| 212                 | filed within I Hygiene. other then *   | E O            | 12th  | College (1-40                  | 1 3+)                                | Cabi                           | net Maker                                  |               |             |   | Ca  | rpenta                              | ry  |  |
| p                   | be filed within 72 ho<br>ital Hygiene.<br>Id other then "natur<br>event, his Mgd fall  | Be             | 17. Father's Name (First, Middle, Last)   |                                |                                      |                                |  |               |             | (First, Middle,                           | Maiden Sur  | name)                               |   |  |
| <u>Ş</u>            |  | 2              | Unknown   |                                |                                      | 105 14-11-                     | q Address (Street a                        |               | nkno        |   | 0.4 T   | 0                                   | 0-41  |  |
| Maryland 21215-0036 | D =  |                | 19a. Informant's Name/Relationship (Type<br>Rodney Donadoni /   |                                |                                      |                                | ndrews Ro                                  |               |             | Burnie                                    | . ,   |                                     | · ·   |  |
|                     | s 1 and<br>of Health<br>item 27<br>other to  | }              | 20a. Method of Disposition  |                                |                                      | Place of Dispo                 | sition (Name of natory or other place      | 1             |             | ate                                       |   | on - City or To                     |   |  |
| Ë                   | Pages<br>nent of I<br>ant: if its  |                | 1 ☐ Burial 2 【 Cremation 3 ☐ Read 4 ☐ Donation 5 ☐ Other (Specify)  | noval from Stat                |                                      |                                | rematory                                   |               | /18/2       | 2006                                      | Baltin  | ore, M                              | Maryland  |  |
| Baltimore,          | permit. Page<br>Department of<br>Important: if<br>any injury or<br>once.   |                | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility G 4001 Ritchie Highw                                  |                                |                                      |                                |  |               |             |   | eral S<br>imore,                                    | ervice<br>Maryl                     | e, P.A.<br>and 21225                            |  |
|                     |  |                | 23a. Part1. Enter the disease, or complica shock, or heart failure. I st only one   | tions that caus                | ed the deat                          |                                |  |               |             | - 7.5.                                    |   |                                     | Approximate<br>Interval Between                 |  |
| A.                  | Physician  |                | Immediate Cause (Final disease or condition  METACATIC CANCER   |                                |                                      |                                |  |               |             |   |   |                                     | Onset and Death                                 |  |
| 1                   | /Medical<br>Examiner   |                | resulting in death)   | Due to (or a                   | is a conseq                          |                                |  |               |             |   |   | 7                                   | 4   |  |
|                     |  | -              | Sequentially list conditions, if any, leading to immediate  | Due to (or a                   | as a conseq                          | uence of):                     |  |               |             |   |   | _                                   |   |  |
|                     | d<br>d<br>ansit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |                                |                                      |                                |  |               |             |   |   |                                     |   |  |
| ó                   | ate be executed<br>hysicien and<br>the burial-transit  |                | resulting in death) Last  | Due to (or a                   | s a conseq                           | uence of):                     |  |               |             |   |   |                                     |   |  |
| 68760,              | The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit | dical          | d.  |                                |                                      |                                |  |               |             |   |   |                                     |   |  |
| 9 ×                 | death certifica<br>ettending ph<br>for use as t  | Physician/Med  | IF FEMALE:  | . If yes, outcom               | ne of pregna                         | ancv                           |  |               |             |   |   | 0-1                                 |   |  |
| Вох                 | etten<br>etten<br>I for u  | cian           | in the past 12 months?  | 1 ☐ Live birth<br>4 ☐ Pregnant | 2 ☐ Fete                             | Ideath 3                       | Ectopic pregnancy Other (specify)          |               |             |   | 230.  | Date of delive<br>Month             | ery<br>Day Year                                 |  |
| P.O.                | t the de<br>by the<br>tached   | hysi           | 1 ☐ Yes 2 昼No<br>9 ☐ Unknown  | 9□ Unknown                     |                                      |                                |  |               |             |   |   |                                     |   |  |
|                     | res tha<br>igned I<br>be det   | by P           | Part II. Dther significant conditions control   |                                |                                      |                                | nderlying cause give                       | en in Part I. |             | 23e. Did to                               | bacco use o   | ontribute to the                    | he cause of death?                              |  |
| ord                 | w require<br>been si<br>should t   | ted            | CHRONE  | 1                              | won u                                | 15 1                           | UNG V                                      | ISCHS         | >5          | 1 U Y                                     | es 2□N  | o 312 Prob                          | bably 4 Unknown                                 |  |
| Records,            | e law<br>has b   | Completed      | Hyrcrien  | SION                           |                                      |                                |  |               |             | 24a. Was a<br>autop                       | sy  | prior to co                         | ppsy findings available<br>mpletion of cause of |  |
| a<br>F              | ician: The l<br>certificete ha<br>rector, page   |                |   |                                |                                      |                                |  |               |             | 1 ☐ Yes                                   |   | death?<br>1 ☐ Yes                   | 2□ No   |  |
| Vital               | Physician:<br>this certificantal director,   | o Be           | 25. Was case referred to medical examiner?  1 Yes 2 No  | spital:                        | tient 2 🗆                            | ER/Outpatien                   | Othe                                       | 00            |             | (Check only or<br>ie 5 ∑Resid             |   | Other (C)                           |   |  |
| of                  | m 0 0  | H 1            | 27. Manner of Death   | 28a. Dale of In<br>(Month, D   |                                      | 28b. Time of<br>Injury         | 28c. Injury                                |               |             | 8d. Describe h                            |   |                                     | y)  |  |
| jö                  | Attending F<br>r death.<br>ector: After<br>by the funera   | atlo           | 1 Matural 5 ☐ Pending 2 ☐ Accident investigation  | (141017811, 2                  | yay roan                             | injury                         |  | Yes 2 1       | No          |   |   |                                     |   |  |
| Division            | or Att   | Certification; | 3 Suicide 6 Could not be determined   | 28e. Place of I<br>building,   | njury - At ho<br>etc. <i>(Specif</i> | o <b>me</b> , farm, stre<br>y) | eet, factory, office                       | -             | 2           | 8f. Location (S<br>City or Tow            |   | mber or Rura                        | al Route Number,                                |  |
|                     | pital  |                | 29a. Certifier 1 Certifying Physic  | ien: To the her                | et of my kno                         | wledge death                   | coourned at the lim                        | o data and    | d place, as | nd due to the                             | 20000/21 200  |                                     |   |  |
|                     | • Hos<br>24 hc<br>• Fun<br>etely   | Medical        | (Check only 2 Medical Examine one)  | r: On the basis<br>and manner  | of examina                           | tion and/or inv                | estigation, in my or                       | oinion, deat  | th occurre  | d at the time, o                          | date and pla  | ce, and due to                      | the cause(s)                                    |  |
|                     | To the Hospital or Attending within 24 hours after death. To the Funeret Director: After completely filled in by the fun   | Me             | 29b. Signature and title of certifier   |                                |                                      |                                | 29c. License                               | number        |             | 2   | 29d. Date sig                                       | ned (Month,                         | Day, Year)                                      |  |
|                     |  |                | ) Lever   | H.D.                           |                                      |                                | D-Z  | Z68           | 09          |   | JULY  | 17-20                               | 206   |  |
| 6                   | . 1  |                | 30. Name and address of person who  | pleted cause of                | f death (Item                        | n 23a) (Type,                  | Print)                                     |               | 0           | 1   | 4 ^ .   | 0                                   |   |  |
|                     |  |                | 31. Date filed (Month, Day, Year)   | 32 Regis                       | trar's Signa                         | TURN                           | ACE BRY                                    | tov CH        | 00          | GUEN                                      | BUKN  | End                                 | 21060.  |  |
|                     | Sta<br>Regist  |                | JUL 2 0 2006  | Bene                           | 1300 1                               | N. 130                         | west                                       |               |             |   |   |                                     | 21060,  |  |

06-05076 Dav

# Please Type or Print in Black Indelible Ink

| id L. Lawler  |                | I- For State  | ate of Maryla   |   | rtment o<br><i>tificate</i> o  |                              | and                   | Menta                    | l Hygien                         | 1 <b>C</b><br>Reg. N               | . 200                                      | 06 22743   |
|---|----------------|---|---|---|--------------------------------|------------------------------|-----------------------|--------------------------|----------------------------------|------------------------------------|--|--|
| Physicia<br>dical Exami   | an/            | 1. Decedent's Name (First, Middle David Lawrence  |   |   |                                |                              | <u>·</u>              | _                        | Mon                              | e of Death                         |  | 3. Time of Death<br>0645 hrs                       |
|   |                | David Lawrence  4a. Facility Name (if not institution  Baltimore Washington                   |   |   | - ·                            | 4b. City, To                 |                       | cation of D              |                                  |                                    | 4c County of De<br>Anne Arund              |  |
| Funeral<br>Director   |                | 5. Social Security Number 217–78–2575   | 6. Sex  | 7. Age (In yrs. la                                  |                                | If Under<br>Months           | 1 Year<br>Days        | If Under 2<br>Hours      | Min                              | ate of Birth (M                    | For  | Birthplace (State or reign Country) MD             |
| v any   |                | Usual Residence of Decedent  10a. State  10b. County  |   |   | Town or Loc                    |                              |                       |                          | -                                |                                    |  | 10d. Inside City Limits 1 Yes 2 X No               |
| Maryland<br>28a-f shov<br>d at once.  | Director       | MD Anne A   | Arundel<br>————   | G.  | len Bu                         | rn1e<br>10f. Zip C           | ode                   |                          |                                  | 10g. Ĉ                             | itizen of What C                           |  |
| eath with the Maryland items 23a or 28a-f show any ust he notified at once.   | Funeral Di     | 1216 Kenwood  11. Marital Status  1 X Never Married 2 Marital Status                          |   | edent Ever in U                                     |                                | Vas Decedent<br>Yes, specify |                       | nic Origin'              |                                  | es or No-                          | White, etc                                 |  |
| P P E   | by Fur         |   | 1 Yes<br>orced If Yes, Give Yea<br>or Dates:  |   | 1 16a. Deced                   | Yes 2 x                      |                       |                          | d of work do                     | ne 16t                             | Specify. Wh                                |  |
| 336<br>thin 72 hound<br>the "nated edical Exa   | Completed      | Elementary/Secondary (0-12)   | College (1  |   | _                              | most of worki<br>iness l     | _                     |                          | e retired)                       | A                                  | utomotiv                                   | re   |
| 1215-00<br>be filed wi<br>ental Hygier<br>rrked other<br>rent, the M  | Be Cor         | 17. Father's Name (First, Middle, Carroll D. La   | wler  |   | 52.253                         |                              |                       | Agnes                    | Mora                             |                                    |  | - Caraca   |
| Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygieria. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. | To             | 19a Informant's Name/Relations William C. La  20a Method of Disposition                       |   | 20b   | 300                            | -                            | stma                  | n Str                    |                                  | Baltim                             | City or Town, Store, MD c. Location - City | 21216  |
| Baltimore,<br>bepartment of Hea<br>Important: If ite  |                | 1 X Burial 2 Cremation 4 Donation 5 Other S   | pecify:   | om State  | crematory or<br>uid Ri         | other place)<br>dge Ce       | mete                  | ry                       |                                  |                                    | ikesvil                                    |  |
|   | ,              | 21. Signature of Funeral Service  | 1   | aused the death                                     | - 1                            | 8728 L                       | iber                  | tv Ro                    | oad, Ra                          | andall                             | stown. M                                   | Directors, Ir. Directors, Ir. Approximate Interval |
| Physician<br>/Medical<br>Examiner   | 7900           | failure. List only one cause  Immediate Cause (Final disease or condition resulting in death) | on each line.<br>a <b>Hypert</b>  | ensive ca   | rdiovas                        |                              |                       |                          |                                  |                                    |  | Between Onset and<br>Death                         |
|   | ner            | Sequentially list conditions, if any, leading to immediate cause. Exter Underlying Couse      | bb  | a consequence (                                     |                                |                              |                       |                          |                                  |                                    |  |  |
| nted<br>d<br>ansit  | Examiner       | (Disease or injury that initiated events resulting in death) Last                             | C.  | a consequence of                                    | of):                           |                              |                       |                          |                                  |                                    |  |  |
| 60,  tte be executed  hysician and  e burial - transit  | Medical        | XXUNPENDED  IF FEMALE:  | AMENDED 23c. If yes,  | item#23a  |                                | Æ,g858,                      | 8/7/0                 | 6 TT                     | _                                |                                    | 23d. Date of deli                          | very   |
| P.O. Box 68760, as that the death certificate be igned by the attending physic of detached for use as the burn  | sician/M       | 23b. Was decedent pregnant in t<br>past 12 months?  | LIVE,   | nant at time of d                                   | eath 5                         | Fetal death<br>Other (Speci  | 3 [                   | Ectopic p                | oregnancy                        |                                    | Month                                      | Day Year   |
| P.O. Be<br>s that the de<br>gned by the   | by Phy         | Part II. Other significant condi  |   | o death but not                                     | resulting in th                | ne underlying                | cause giv             | en in Part               | I. 2                             |                                    |  | to the cause of death?  Probably 4  Unknown        |
| cords,<br>aw requirents been sing 2 should b  | Completed      |   |   |   |                                |                              |                       |                          |                                  | 4a. Was an autopsy performed Yes 2 | prior                                      |  |
| /ital Rec ysician: The l nis certificate l director, page   |                | 25. Was case referred to medical examiner?  |   | Inpatient 2   | FR/Qutpati                     |                              |                       | Alban                    | Check only or<br>Nursing Hom     | ne)                                |  | ther:  |
| on of Vit<br>anding Physic<br>tth<br>r: After this  | tion: To       |   | 28a. Date (Mont   |   | 28b. Time                      |                              | Bc. Injury            | at Work?                 | 28d. [                           |                                    | injury occurred                            |  |
| Division of Nespital or Attending Ph 24 hours after death Funeral Director: After titely filled in by the funeral   | Certification: | 3 Suicide 6 Cou   | estigation 28e. Planular 28e. | ce of Injury - At I                                 | home, farm, s                  | treet, factory,              | office bu             | ilding, etc.             |                                  | ocation (Stree<br>or Town, State   |  | Rural Route Number, City                           |
| To the Hosp<br>within 24 hor<br>To the Fune<br>completely fi  | Medical C      | 29a. Certifier 1 Certifying F   | Physician: To the be<br>aminer:On the basis<br>and manner   | of examination                                      | dge, death or<br>and/or invest | curred at the igation, in my | time, dat<br>opinion, | e and plac<br>death occu | e, and due to<br>urred at the ti | ime, date and                      | place, and due t                           | o the cause(s)                                     |
| H 3 F 5   | N.             | 29b. Signature and title of certif  | ell )G  | X. Ta   | A W                            | <b>1</b> 29c                 | O.C.N                 |                          |                                  |                                    | uly 16, 2006                               | (Month, Day, Year)                                 |
|   |                | 30. Name and address of perso<br>Theodore M. King, Jr   | ., MD. Assist   | use d' death (Ite<br>ant Medical<br>gistrar's Signa | Examiner                       | 111 Pe                       | nn Stre               | eet, Balt                | imore, MI                        | D 21201                            |  |  |
| Regi  | State<br>stra  | OUL Z   | 0 2006  | gistrar s Signa                                     | 1. 19                          | neith)                       |                       |                          |                                  |                                    |  |  |
| HMH 17 Rev 1  | /2001          |   |   |   | ORIĞI                          | NAL                          |                       |                          |                                  |                                    |  |  |

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Mary Katherine Lively Certificate of Death 1- For State Reg No Registrar Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day July 13, 2006 1451 hrs **Medical Examiner** Mary K. Lively 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Cecil Rising Sun Horseshoe Road @ Route 1 9. Birthplace (State or If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex **Funeral** Min Foreign Hours Months Davs Director 159-24-8310  $_{2}X$ 1928 Pennsylvania 1 M 77 July 16, Usual Residence of Deceder 10d Inside City Limits Oc. City, Town or Location Ž 10a. State 10b. County 1 Yes 2 X No or items 23a or 28a-f show must be notified at once. Rising Sun Cecil permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 160 Codjus Drive 21911 USA ā 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Funera 11 Marital Status Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes 2 X No 1 Yes 2 X No specify f Yes, Give Year Specify: white 3 X Widowed Divorced ş 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Flementary/Secondary (0-12) 21215-0036 0 housewife own home 18 Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Abbie Jeanett Mellott æ John Harvy Tritle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print ) ဥ Itimore, MD Darlene J. Brack/daughter 160 Codjus Drive Rising Sun, MD21911 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify: 21. Signature of Fall Service Licen de, 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director IRaltimore, MD 21201 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval ort I. Enter the disease, or **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed and Physician/Medical AMENDED UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760. 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Ectopic pregnancy 3 Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions ð Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an this certificate has been autopsy prior to completion of cause of death? performed? ✔ Yes 2 1 🗸 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medica Hospital or Attending Physician: 24 hours after death Be Other: examiner? Hospital. Nursing Home 5 Residence 6 ✓ Other: Scene Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day, Year FOUND: 28c. Injury at Work' 28d. Describe how injury occurred After 28b. Time of Injury 27. Manner of Death Certification: Driver auto fixed object collision FOUND: Natural Yes 2 V No Pending Director: Jul 13, 2006 1451 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e Place of Injury - At home, farm, street, factory, office building, etc completely filled in by 3 Could not be or Town, State) Suicide determined (Specify) Local Street Horseshoe Road 1 mile off Route 1, Rising Sun, 24 hours a Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) and manner stated 29c License numbe 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier July 14, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD

Registrar DHMH 17 Rev 1/2001 OCMF 2006

State

31 Date filed (Month, Day, Year)

32 Registrar's Signati

006

|  |   | 1                     | For State Registrar   | State of   | Maryland                         |                     | artment of H                             |                      | d Mental H                       | Hygiene<br>Reg. No              | allin.                     | 22745  |  |
|--|---|-----------------------|---|--|----------------------------------|---------------------|--|----------------------|----------------------------------|---------------------------------|----------------------------|--|--|
|  | 79  |                       | Decedent's Name (First, Middle  | e, Last)   |                                  |                     |  |                      | 2. Date of<br>Month              |                                 | y Year                     | 3. Time of Death                                     |  |
|  | Physicia /Medic   | _                     | JOHN  |  |                                  |                     | LANGDON                                  |                      | JULY                             |                                 |                            |  |  |
|  | Examin  |                       | a. Facility Name (If not institution  |  | oer)                             |                     | 4b. City, Town, o                        |                      | Death                            | 1                               | 4c. County of Death  n/a   |  |  |
|  | * 3   | *                     | 4710 RASPE A Social Security Number   |  | Age (In yrs. I                   | ast hirthday)       | If Under 1 Year                          | If Under 24          |                                  | Birth                           | 9. Bi                      | thplace (State or Foreign                            |  |
|  | Funeral<br>Director   | 5                     | 217–18–2792   | 1. XM 2□F  | 82                               |                     | Months Days                              | Hours 1              | Min. (Month                      | , Day, Year)<br><b>0–192</b> 4  |                            | ountry)<br>RYLAND                                    |  |
| TO   |   |                       | Jsual Residence of Decedent   |  |                                  |                     |  |                      |                                  |                                 |                            | 10d. Inside City Limits                              |  |
| arylan   | ahow<br>dat   |                       | MD 10b. County  | BALTIMORE  | 10c. City                        | y, Town or Lo       |  | EDALE                |                                  |                                 |                            | 1 Yes 2 No   |  |
| he M   | Sa-f  | Director              | Oe. Street and Number   |  |                                  |                     | 10f. Zip Code                            |                      |                                  | 10g. Cit                        | tizen of What C            | ountry?  |  |
| with (   | Len   | 급                     | 7508 BRIGHTSID  | E AVENUE   |                                  |                     |  | 21237                |                                  |                                 | U.S.A                      | •  |  |
| death  | ms 23   | Funeral               | 11. Marital Status  | 12. Was Deced  |                                  | S. 13.              | Was Decedent of H                        | fispanic Origin      | ? (Specify Yes o                 | No-                             | 14. Race - Am<br>Black, Wh |  |  |
| after  | or ite  |                       | 1 Never Married 2 Mar   | ned 1 XYes 2   | ! □ No                           |                     | 1 ☐ Yes 2 X No                           |                      |                                  | <b>'</b>                        |                            | WHITE  |  |
| :1215-0036<br>within 72 hours after death with the Maryland  | ural.   | d by                  | 3 ☐ Widowed 4 M Divorced  | Year or Dat  | es: WWII                         | 16a Dece            | dent's Usual Occup                       | nation               |                                  | 16b. K                          | (ind of Busines            |  |  |
| 15-<br>0 72 1  | "nat  | lete                  | (Specify only highe   | nt's Education<br>est grade completed)                       | 45-1                             | (Give               | kind of work done DO NOT use retire      | during most of<br>d) | f working                        |                                 |                            | -  |  |
| 212<br>1 with  | r thar  | Completed             | Elementary/Secondary (0-12)   | College (1-  | +Or 5+)                          | SHEE                | T METAL W                                | ORKER                |                                  | [M]                             | ARTINS                     | MARIETTA   |  |
| Ind 2  | at Hyg  | BeC                   | 17. Father's Name (First, Middle,   |  | a a consta                       |                     |  | 18. Mother's         | Name (First, Mid<br>T MTNA       | ddle, Maider                    |                            | GEN)   |  |
| aryla i  | Ment<br>arked<br>atic   | 9                     | GEORGE  |  | ANGDON                           | 40h 14-9            | ing Address (Street                      |                      |                                  | imher City                      |                            |  |  |
| Maryland 21215-0036 at 2 should be filed within 72 hours aft | f Health and Mental Hygiene.<br>Item 27 is marked other than "natural" or Items 23s or 28s-1 show<br>other traumatic event, the Medical Examinar natal be notified at | ١,                    | 19a. Informant's Name/Relations<br>KENNETH LANGDON  |  |                                  |                     | RASPE AV                                 |                      |                                  | 'IMORE                          |                            | 21206  |  |
| 1 and  | Healt<br>em 2<br>ther   |                       | 20a. Method of Disposition  | i, boit  | 20b. P                           |                     | osition (Name of<br>ematory or other pla |                      | Date                             |                                 | ocation - City o           | r Town, State  |  |
| nor<br>ages  | ant of<br>at: If It<br>y or o   |                       | 1 ☐ Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☑ Other (S   | 3 □Removal from S  |                                  |                     |  |                      | 7-21-200                         | 6 B                             | ALTIMOR                    | E, MD  |  |
| Baltimore,   | Department of h<br>Important: If Ite<br>sny injury or of<br>once.   |                       | 21. Signatur 1 Funeral soice  |  |                                  | 2                   | 2. Name and Addre                        | ess of Facility      |                                  |                                 |                            |  |  |
| Ö E  | lmpo<br>sny ir  |                       | 100   | <b>S</b>   |                                  |                     | 1211 CHES                                |                      |                                  |                                 | ALE, MD                    |  |  |
|  |   |                       | 23a. Part1. Enter the disease, o shock, or heart failure. Lis   | r complications that ca<br>t only one cause on ea            | ch line.                         |                     |  |                      |                                  | ory arrest,                     |                            | Approximate<br>Interval Between<br>Onset and Death   |  |
|  | nysician  |                       | Immediate Cause (Final disease or condition resulting in death)   | -a. K  | STAT                             |                     | CANO                                     | ELC                  |                                  |                                 |                            |  |  |
|  | Medical xaminer   |                       | resulting in death;   | Due to (d  | or as a conseq                   | juence of):         | CANC                                     | ATA                  | 512                              |                                 |                            |  |  |
|  | 18:   | ا <u>ة</u>            | Sequentially list conditions, if any, leading to immediate  | b. Due to (c   | or as a conseq                   | uence of):          | 11.6                                     | 102 7 79             | , -                              |                                 |                            |  |  |
| / beta   | ansit   | Examiner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | <b>1</b> .   |                                  |                     |  |                      |                                  |                                 |                            |  |  |
| 0,<br>exec   | sician and<br>burial-fransit  | Exa                   | resulting in death) Last  | Due to (d  | or as a conseq                   | quence of):         |  |                      |                                  |                                 |                            |  |  |
| 8760,  | hysici<br>the bu  | dicai                 |   | d  |                                  |                     |  |                      |                                  |                                 |                            |  |  |
| Records, P.O. Box 68760, <                                   | attending phy<br>I for use as the   | Physician/Med         | IF FEMALE:  | 23c. If yes, outo  | come of pregna                   | ancy                |  |                      |                                  |                                 | 23d. Date of d             | elivery  |  |
| Box<br>eath cert   | ed by the attendir<br>detached for use  | clan                  | 23b. Was decedent pregnant in the past 12 months?   | 1 ☐ Live bi  | nth 2 ☐ Feta<br>ant at time of c | al death 3          | □Ectopic pregnand □ Other (specify) _    | у                    |                                  |                                 | Month                      | Day Year   |  |
| P.O.   | by the<br>tached  | yst                   | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9□ Unkno   | wn                               |                     |  |                      |                                  |                                 |                            |  |  |
| S, D   | been signed t   | by P                  | Part II. Other significant condit   | tions contributing to de                                     |                                  | sulting in the      | underlying cause gi                      | ven in Part I.       | 23е.                             |                                 |                            | to the cause of death?                               |  |
| ords   | en sig  | led t                 | 14/164  | - ( EN 316   | 2                                |                     |  |                      |                                  | 1 Yes 2                         | No 3                       | Probably 4 Unknown                                   |  |
| Records,   | as be   | Completed             |   |  |                                  |                     |  |                      |                                  | Was an<br>autopsy<br>performed? | 24b. Were prior to death   | autopsy findings available<br>completion of cause of |  |
|  | cate h  | S                     |   |  |                                  |                     |  |                      | 101                              | es P                            |                            | es 2 No  |  |
| of Vital   | certifi   | Be                    | 25. Was case referred to medic examiner?  | Hospital:  | npatient 2                       | TER/Outpate         | ent 3 DOA                                | ther                 | of Death (Check of Sing Home 5 🗆 |                                 | 6 Other (S)                | PORTE HOME   |  |
| o a  | rthis<br>aral di  | . To                  | 1 Yes 2 No 27. Manner of Death  |  | of Injury<br>h, Day Year)        | 28b. Time<br>Injury | of 28c. Inju                             |                      |                                  |                                 | ury occurred               | SWOIL CHOCK  |  |
| /ision   | ath.<br>r: Afte   | atlo                  | 2 LI ACCIDENT   | tigation   | ii, Day 1 bai)                   | Injury              |  | Yes 2 N              | 0                                |                                 |                            |  |  |
|  | er de<br>recto<br>by th   | tific                 | 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter  | 280. Place   | of Injury - At h                 | nome, farm, s       | street, factory, office                  | •                    |                                  | ion (Street a<br>or Town, Sta   |                            | Rural Route Number,                                  |  |
| الم الم  | rs aft<br>ral Di  | Cer                   | 10  | ring Physician: To the                                       |                                  |                     | - A - A - A - A - A - A - A - A - A - A  | uma data and         | place and due !                  | a the cause                     | c) and manner              | as stated  |  |
| ] January  |   | edical Certification: | 29a. Certifier Certify (Check only 2 Medics one)  | ring Physician: 10 the<br>al Examiner: On the ba<br>and mani | sis of examin                    | ation and/or        | investigation, in my                     | opinion, death       | occurred at the                  | time, date a                    | nd place, and d            | ue to the cause(s)                                   |  |
| 4  | within 2<br>To the<br>comple  | Mec                   | 29b. Signature and title of certif  |  | Λ                                |                     | 29c. Licer                               | nse number           |                                  | 29d. D                          | ate signed (Mo             | nth, Day, Year)                                      |  |
| ľ  | - s <del>-</del> ō  |                       | Military M  | what   | Jan                              | M                   | D-                                       | 4802                 | 5                                | 7                               | -17-0                      | 96   |  |
| Q  | (+1   |                       | 30. Name and address of person  | on who completed caus  | e of teath (Ite                  | om 23a) (Typ        | e, Print)                                | ~ B                  | ve, B                            | alty                            | ND 21                      | 237  |  |
|  | Si  | ate                   | 31. Date filed (Month, Day, Yea   | 32. R  | egistrar's Sign                  | nature              |  |                      | <u> </u>                         |                                 |                            |  |  |
|  | Regis   | trar                  | YT Y  | 2 0 2006   | 10.00                            | H                   | (posts)                                  |                      |                                  |                                 |                            |  |  |

DHMH 17 Rev 1/2001

ORIGINAL

|                      |  |                | For<br>State<br>Registrar   | State of Maryla   |                                    | artment of rtificate of                                |                                      | d Mer                   |                                    | ene<br>g. Nq2 () (                 | 16                     | 22746   |
|----------------------|--|----------------|---|---|------------------------------------|--|--------------------------------------|-------------------------|------------------------------------|------------------------------------|------------------------|---|
|                      | Physici  |                | 1. Decedent's Name (First, Middle, Last)  | Marcus Garve  | y Laure                            | nt   |                                      |                         | Date of Death<br>Month<br>July 1:  | Day                                | Year                   | 3. Time of Death  11:00A M                            |
| 14                   | /Medic<br>Examin   |                | 4a. Facility Name (If not institution, give s   | street and number)  |                                    | 4b. City, Town,  | or Location of D                     | eath                    |                                    | 4c. County of                      | of Death               |   |
|                      |  | ÇILÎY.         | 18 South Duke Str   |   |                                    | Rockvi   |                                      | l leo -                 |                                    | Montg                              | omer                   | У   |
|                      | Funeral<br>Director  |                | 103-00-3700   | 7. Age (In yrs  | s. last birthday)<br>Yrs.          | Months Day   |                                      | vin                     | Date of Birth (Month, Day, ept. 9, | <sup>Year)</sup> 1923              | 9. Birthi<br>Cou<br>Ha | place (State or Foreign<br>ntry)<br>iti               |
|                      | land<br>ww   |                | Usual Residence of Decedent  10a. State 10b. County   | 10c. C  | City, Town or Lo                   | ocation  |                                      |                         |                                    |                                    | T                      | 10d. Inside City Limits                               |
|                      | Mary<br>Bed eh   | tor            | Maryland Montgome   | ry  |                                    | Rocky  | ville                                |                         |                                    |                                    |                        | 1 ☑ Yes 2 ☐ No  |
|                      | or 28  | Director       | 10e. Street and Number  |   |                                    | 10f. Zip Code  |                                      |                         | 10                                 | g. Citizen of W                    |                        | ntry?   |
|                      | sath w   | erai           | 18 South Duke Str   | 12. Was Decedent Ever in  | 115 13                             |  | 20850                                | 2 (Specify              | Ves or No-                         | Haiti                              |                        | can Indian,   |
| 36                   | d within 72 hours after death with the Maryland<br>jene.<br>Ir than "natural", or Itema 23a or 28a-f ehow<br>The Modical Exacultational Le notified at | by Funerai     | 11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced   | Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:                                  |                                    | Was Decedent of<br>If Yes, specify Cu<br>1 ☐ Yes 2 ☑ N |                                      | uerto Rica              | an, etc.)                          |                                    | k, White,              | etc.  |
| 200                  | 72 hor   | eted           | 15. Decedent's Edu<br>(Specify only highest grade   |   | 16a. Dece                          | dent's Usual Occ                                       | upation<br>e during most of          | working                 | 1                                  | 16b. Kind of Bu                    | siness/ln              | dustry  |
| 21215-0036           | within<br>ene.<br>than "   | Completed      | Elementary/Secondary (0-12)   | College (1-4or 5+)  | life.                              | DO NOT use reti  | red)                                 | 3                       |                                    | Public                             | Sar                    | rvice   |
| 22                   | filed w<br>Hygie<br>other th   |                | 17. Father's Name (First, Middle, Last)   | 5+  | Unite                              | u Natio  |                                      |                         | irst, Middle, N                    | faiden Sumame                      |                        | VICE  |
| Maryland             | d a b  | To Be          | Obed Laurent  |   | 40) 44 17                          |  | Dina                                 | Ber                     | nard                               |                                    |                        | 0.41  |
| Mai                  | 2 a 9 a  |                | 19a. Informant's Name/Relationship (Ty.) Clara Laurent/Wife   |   |                                    | ng Address <i>(Str</i> e<br>uth Duke                   |                                      |                         |                                    | -                                  |                        |   |
|                      | of Health<br>of Health<br>I Item 27<br>r other ti  |                | 20a. Method of Disposition  | 20h   | Place of Disno                     | osition (Name of                                       |                                      | ı 1y Date               |                                    | 20c. Location - (                  |                        |   |
| Ë                    | Page<br>net o<br>int: If<br>iry or   |                | 1 ☐ Burial 2 ② Cremation 3 ☐ P<br>4 ☐ Donation 5 ☐ Other (Specify)  | Removal from State Mo<br>Cr   | ntgomer                            | matory or other p<br>Y<br>um, Inc                      | . 2                                  | 2006                    |                                    | ethesda                            | , Ma                   | ryland  |
| Baltimore,           | permit. Pages. Department of h Important: If ite eny injury or of  |                | 21. Signature of Funeral Service License  | 99  | R.C                                |  | ress of Facility                     | y Fu<br>y Ave           | neral                              | Home/Rokville,                     | ckvi<br>MD 2           | lle, Inc.<br>20850-2805                               |
|                      | Physician<br>/Medical  |                | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) | ne cause on each line. Prostate C   | ancer                              | ter the mode of d                                      | ying, such as car                    | rdiac or re             | spiratory arre                     | st,                                | 2                      | Approximate Interval Between Onset and Death 23 Years |
| 68760,               | death certificate be executed x x x and a settending physician and a for use as the burial-transit   | licai Examiner | cause. Enter Underlying Cause (Disease or injury  | Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.            | uence of                           |  |                                      |                         |                                    |                                    |                        |   |
| P.O. Box 68          | it the death certifica<br>by the attending ph<br>tached for use as th  | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown   | 23c. If yes, outcome of preg<br>1 Live birth 2 Fe<br>4 Pregnant at time of<br>9 Unknown | tal death 3                        | ☐Ectopic pregnar<br>☐ Other (specify)                  |                                      |                         |                                    | 23d. Date<br>Mon                   |                        | ery<br>Day Year                                       |
| of Vital Records, P. | signed<br>signed<br>d be de  | by             | Part II. Other significant conditions con<br>Arteriosclerotic F   |   |                                    | inderlying cause (                                     | given in Part I.                     |                         |                                    |                                    |                        | he cause of death?                                    |
| S                    | law requas been 2 shoul  | Completed      | Diabetes Mellitus   | II  |                                    |  |                                      |                         | 24a. Was ar                        |                                    | /ere auto              | opsy findings available                               |
| Æ                    | cate ha  | mo             |   |   |                                    |  |                                      |                         | autopsy<br>perform<br>1 Yes 2      | ned? de                            | eath?                  | mpletion of cause of<br>2 No                          |
| /ita                 | detidios<br>certifica<br>rector.   | Bec            | 25. Was case referred to medical examiner?  |   |                                    |  |                                      | Death (C                | heck only one                      |                                    |                        |   |
| of \                 | this<br>al di  | 2              | 1 ☐ Yes 2 ☒ No  27. Manner of Death   | 1 Inpatient 2   | ☐ ER/Outpatie                      | IL 3 DOA   |                                      |                         |                                    | nce 6 Othe                         |                        | <del>(y)</del>  |
| O                    | ling<br>After<br>une   | tion           | 1 ⊠ Natural 5 □ Pending 2 □ Accident investigation  | 28a. Date of Injury<br>(Month, Day Year)  | Injury                             | W  | ork?<br>☐ Yes 2 ☐ No                 | 260                     | . Describe no                      | w injury occurre                   | ,u                     |   |
| Division             | I or Attending after death. Director: After din by the fune  | Certification: | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At building, etc. (Spec  | home, farm, st<br>cify)            | reet, factory, offic                                   | 0                                    | 28f.                    | Location (Str<br>City or Town      |                                    | or Aun                 | al Route Number,                                      |
| _                    | Hospita<br>4 hours<br>Funeral<br>ely fillec  | edical C       | 29a. Certifier (Check only one)  1 Certifying Phy. 2 Medical Exami  | sician: To the best of my kiner: On the basis of examinand manner stated.               | nowledge, deal<br>nation and/or in | h occurred at the<br>evestigation, in my               | time, date and p<br>opinion, death o | lace, and<br>occurred a | due to the ca                      | use(s) and mar<br>ite and place, a | nner as s              | itated.<br>o the cause(s)                             |
|                      | To the within 2 To the complet   | Me             | 29b. Signature and title of certifier   | NI  | 7                                  | 29c. Lice  | nse number                           |                         | 29                                 | d. Date signed                     | (Month,                | Day, Year)  |
|                      |  |                | 4 ( and   | 1   |                                    | D  | 23783                                |                         |                                    | July                               | 17                     | , 2006  |
| 5                    | 57   |                | 30. Name and address of person who or Daniel J. Esposito  | o, M.D. 5530  | ) Wiscon                           | nsin Ave   | .,#1400,                             | , Che                   | vy Cha                             | se, Mar                            | ylar                   | nd 20815  |
|                      | Sta<br>Regist  |                | 31. Date filed (Month, Day, Year)  JUL 2 0 2  | 32. Registrar's Sig   | nature A                           | paste  |                                      |                         |                                    |                                    |                        |   |

|                     |   |                     | For State   | State of Maryland  | d / Dep             | artment of H   | lealth and                 | _   | •   | 22747   |
|---------------------|---|---------------------|---|--|---------------------|--|----------------------------|---|---|---|
|                     |   |                     | Registrar  1. Decedent's Name (First, Middle, Last,   | 1  | Ce                  | rtificate of   | Death                      | 2. Date of De                             | Reg. No.  | 3. Time of Death  |
|                     | Physicia<br>/Medic  |                     | ,   | Arlene Queen   | Locke               |  |                            | 2 mghth                                   | 16, Zoof  | 5:00 PM   |
|                     | Examin  | er                  | <u> </u>  | くしん ひっしょうくりゃ   | 7 Me                | 4b. City, Town, o  | Location of De             | -lan 18                                   | 4c. County of Death   | uns Huma  |
|                     | Funeral<br>Director   |                     | 5. Social Security Number 6. Security Number 162 12 6315  | 7. Add fn yrs. I   | Yrs.                | Months Days  | Hours Mi                   | n. (Month, Da                             | 9, 1918 Per   | nplace (State or Foreign<br>untry)<br>nnsy1vania            |
|                     | aryland<br>show   | _                   | 10a. State 10b. County  |  | y, Town or L        |  |                            |   |   | 10d. Inside City Limits 1 ☐ Yes 2 No                        |
|                     | the M   | recto               | Maryland Anne Art   | indel G  | len Bu              | 101. Zip Code  |                            |   | 10g. Citizen of What Co                                       |   |
|                     | th with   | a Di                | 7355 E. Furnace   | Branch Road  |                     | 210  | 060                        |   | U.S.  |   |
| 920                 | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural, or items 23a or 28a-f show other traumatic svent, the Madical Examinal must be notified at | by Funeral Director | 11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced   | 12. Was Decedent Ever in U.<br>Armed Forces?<br>1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates: | S. 13.              | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 ☑ No  |                            | (Specify Yes or No<br>erto Rican, etc.)   | 14. Race - Ame<br>Black, White<br>Specify: Wh:                | e, etc.   |
| 2-0                 | natur   | Completed           | 15. Decedent's Edu<br>(Specify only highest grad  |  | 16a. Dece<br>(Give  | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | oation<br>during most of w | vorking                                   | 16b. Kind of Business/  | Industry  |
| 2121                | withir<br>piene.<br>r than  | ошо                 | Elementary/Secondary (0-12) 12th  | College (1-4or 5+)   |                     | emaker   | 0)                         |   | Own Home  | 9   |
| Maryland 21215-0036 | 2 should be filed<br>and Mental Hygli<br>is marked other<br>sumatic event.  | To Be C             | 17. Father's Name (First, Middle, Last) Charle  | es B. Lane   |                     |  |                            | <sub>ame (First, Middle</sub><br>da Swope | , Maiden Surname)   |   |
| Mary                | t 2 should<br>h and Men<br>7 is marks<br>rsumatic   |                     | 19a. Informant's Name/Relationship (7) Kenneth Locke / S  |  |                     | -  |                            |   | er, City or Town, State, 2<br>Maryland 21:                    |   |
|                     | s 1 and<br>f Health<br>item 27<br>other tr  |                     | 20a. Method of Disposition  |  |                     | osition (Name of matory or other plan                        |                            | Date Date                                 | 20c. Location - City or                                       |   |
| imo                 | Page<br>nent c<br>ant: If<br>ury or   |                     | 1 ☑ Burial 2 ☐ Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)  | 101110Vat IIOIII State   | en Hav              | en Mem. P  | ark 7/1                    | 9/2006                                    | Glen Burnie   | , Maryland  |
| Baltimore,          | permit. Pages 1 and 3<br>Department of Health<br>important: If item 27<br>any injury or other tra<br>once.  |                     | 21. Signature of Puneral Service Licens   |  | 4                   |  | nie High                   | way Balt                                  | neral Servic<br>timore, Mary                                  | e, P.A.<br>land 21225                                       |
|                     | ē.  |                     | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only o<br>Immediate Cause (Final                          | lications that caused the death<br>ne cause on each line.  | h. Do not en        | ter the mode of dyir   | ng, such as card           | iac or respiratory a                      | irrest,   | Approximate<br>Interval Between<br>Onset and Death          |
| Acres 1             | Physician<br>/Medical   |                     | disease or condition resulting in death)  | a  | uence of):          | 122  |                            |   |   |   |
|                     | Examiner  | _                   | Sequentially list conditions,   | b<br>Due to (or as a consequ   | uence of):          |  |                            |   |   |   |
|                     | uted<br>d<br>ansit  | mine                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | c  | 201100 0171         |  |                            |   |   |   |
| 760,                | te be executed<br>ysicien and<br>e burial-transit   | cai Examiner        | resulting in death) Last  | Due to (or as a consequent   | uence of):          |  |                            |   |   |   |
| 6876                | ficate by   |                     |   | d.   |                     |  |                            |   |   |   |
| Вох                 | The law requires that the death certificate be executed ate has been signed by the elending physicien and page 2 should be detached for use as the burial-transit   | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome of pregna<br>1 Live birth 2 Feta<br>4 Pregnant at time of di<br>9 Unknown   | Ideath 3í           | □Ectopic pregnanc<br>□ Other (specify) _                     | у                          |   | 23d. Date of del  | very  |
| rds, P.O.           | quires that t<br>in signed by<br>uld be deta  | ed by Ph            | Part II. Other significant conditions co  | ntributing to death but not resi   | ulting in the i     | underlying cause giv   | ven in Part I.             | 23e. Did 1                                | tobacco use contribute to                                     | the cause of death?   |
| I Records,          | The law requir<br>ate has been si<br>page 2 should I  | Completed by        |   |  | 01                  |  |                            | 24a. Was<br>auto<br>perfo<br>1 Yes        | psy prior to operated? 24b. Were au prior to operated? death? | topsy findings available<br>completion of cause of<br>2.3 o |
| Vital               | Physicien:<br>this certific<br>ral director,  | Be                  | 25. Was case referred to medical examiner?  | Hospital:  | ED/0                | Ott  | 200                        | Death Check only                          |   |   |
| Division of         | To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funersi Director: After this certificate has completely filled in by the funeral director, page 2   | tion: To            | 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of Injury | of 28c. Inju   | 4 CHARLENIA                |   | idence 6 Other (Specification of the following occurred       | ony)  |
| Divisi              | ei or Atter<br>s atter dea<br>i Director<br>id in by the  | Certification:      | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Injury · At he building, etc. (Specification)                                      | ome, farm, si       | reet, factory, office  |                            | 28f. Location (<br>City or To             | (Street and Number or Ruwn, State)                            | iral Route Number,  |
|                     | ne Hospitei<br>24 hours a<br>ne Funerai b<br>Hetely filled  | Medical C           |   | vsician: To the best of my kno<br>iner: On the basis of examina<br>and manner stated.            |                     |  |                            |   |   |   |
|                     | To th<br>within<br>To th<br>comp  | M                   | 29b. Signature and title of certifier   | 200  |                     | 29c. Licens  | se number                  |   | 29d. Date signed (Monti                                       | n, Day, Year)   |
|                     | DI  |                     | 30. Name and address of person who  | ompleted cause of death (Item  | n 23a) (Typo        | Print)   | 800x                       | /   | 1116 20   | Vb  |
| ,                   | 2   |                     | KOF, BOM  | TEY,   | 301                 | Hosp-  | ita/i                      | gr. C                                     | 71en 150  | Clu Hinn  |
|                     | Sta<br>Regist   |                     | 31. Date filed (Month, Day, Year)   | 32. Resider's Signa  | H.                  | Sparles  |                            | /   |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #5 Per FH C857 7/28/06 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Rober 637PM 2006 15 Ju /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba Maryland Himore Medical Baltimore Center If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 MM 2□ F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 2613 Shirley VR Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Completed by I Specify: 4 Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Coment Elementary/Secondary (0-12) College (1-4or 5+) orzman 10th CONSMUCE ::-18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be NNIE Wiggins 11125 ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wite 2613 Shirley 1athleen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 22/06 4 □Donation 5 □Other (Specify) Lansdowne Cemerery 21. Signature of Funeral Service Licensee harman -Harris 22. Name and Address of Facility 5240 Reisterstown Rd Battimore 2/2/2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hemorrhand **Physician** -htra cranial Due to (or as a consequence of): /Medical erforated **Examiner** VISCUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐ Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2X No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No Other: 2 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2006 17511 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 118 N Howar Christopher Daltimire MA 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

06-04978 Henry L. Moore Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Year 1635 hrs July 12, 2006 Moore Sr. Medical Examiner Lovelle Henry 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Gwynn Oak **Baltimore County** 7105 Manila Avenue 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY 5. Social Security Number 7 Age (In yrs last birthday) 6 Sex **Funeral** Min Months Days Hours 04 20 45 MD Director Country) 61 215-46-9575 1**X** M 2 Usual Residence of Deceden 10a State 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 No Woodlawn 28a-f show or items 23a or 28a-f show must be notified at once. MID NA nore, MD 21215-0036
ages 1 and 2 should be filed within 72 hours after death with the Maryland
and Realth and Mental Hygiene.
it: If item 27 is marked other than "natural", or items 23a or 28a-f sho
other tranmatic event, th. Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10f. Zip Code 10e Street and Number Manilla U.S.A. 21244 7105 Manila .Ave Funeral 13 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. White, etc Armed Forces' 1 Never Married 2 Married 2 X No Yes Black Specify. 4 X Divorced Give Year Yes 2 X No specify. Widowed ğ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15 Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Baltimore Gas & Elementary/Secondary (0-12) College (1-4 or 5+) Electric Company Power Plant Engineer 4yrs 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Naomi Daughtry <u>Louis Moore</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) 2 Loch Hill Road, Baltimore, 21239 Lynnette Moore-Daughter 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Pages 1 1 X Burial 2 Cremation 3 Removal from State Department o
Important: Randallstown, Mã 7/19/06 Memorial Park Donation 5 Other Specify King 22. Name and Address of Facility sture of Funeral Service Lice March F/H West
4300 Wabash Ave, Baltimore, I
aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21215 Baltimore, Md Part I. Ententhe disease, or complications that of allure. List only one cause on each line. Approximate Interval Physician Setween Onset and /Medical Death a Intracerebral Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed and Physician/Medical x AMENDED 10e per fh g857 7-20-06 vt UNPENDED attending physician or use as the burial 68760. 23d Date of delivery 23c. If yes, outcome of pregnancy IE EEMALE 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I by 1 o ð Yes 2 No 3 Probably 4 ✔ Unknown σ. Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy The law r performed? death? certificate has ✓ Yes 2 1 🗸 Yes 2 No 26 Place of Death (Check only one 25. Was case referred to medical Hospital or Attending Physician: of Vital Be Hospital: 1 examiner? Other<sub>4</sub> Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA Nursing Home 5 Inpatient this 1 🗸 Yes 7 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death After 1 V Natural Division Yes 2 No Pending death the Director: Certificati 2 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined within 24 hours a

To the Funeral 1 4 Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certify O.C.M.E July 13, 2006 i030 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD 31. Date filed (Month, Day, Y 32. Registrar's Signature State 2006 Collins Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#20b, perFH, e857, 7/20/06 TT

Amend Item 12 perInf, G857, 06 TT

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Ame 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17, 2006 3:50 P.M Physician TELLY Mutchell Alphonso Lee /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Memorial Hospital Baltimore N lunion If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday)
Yrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1**X**M 2□ F 213.20.7489 02/12/1925 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Deperiment of Health and Mental Hygiene.
Important: If item 27 is marked other then "netural", or iteme 23e or 28e-f ehow empiripary or other treumatic event, the Mudical Examinar must be notified at once. 10a State 10b. County Baltimore 1 Yes 2 No MD Baltimore **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 8651 irdo 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black À 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) ntary/Secondary (0-12) eldung Welder Loth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unde Mitchell Gracie Darden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ant's Name/Relationship (Type, Print) Beatrice Hopkins/Daughter 8051 Baltimore MD 21236 Saxon Circle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 07/25/06 1 Surial 2 Cremation 3 Removal from State Garnson Forest 07/24/06 4 □Donation 5 □ Other (Specify) Mo1363 22 Name and Address of Facility
Volugian C. Sveene Funem (See Address of Facility
Volugian C. Sveene Funem (See Address of Facility) 21. Signature of Funeral Service Licensee Service 12 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAGE RENAL DISEASE END YEARS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Box 68760 physiclen Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ MELLITUS 1 Yes 2 No 3 Probably 4) Unknown Be Completed PERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 1 ☐ Yes 1 ☐ Yes 2 No : After this certifical funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 27. Manner of Death 28a. ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Natural Accident To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D47/23 JULY 17, 2006 ellumana 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DKNY JOSEPH PUTHUNDANA BALTIMORE MD21216 UNION, MEM-HOSD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

|                          |  |                  | 1 - For State Registrar  | State of Maryla   |                                     | artment o   |                                   |             |   | giene 2         | 006                   | 22751  |
|--------------------------|--|------------------|--|---|-------------------------------------|---|-----------------------------------|-------------|---|-----------------|-----------------------|--|
|                          | DI   |                  | 1. Decedent's Name (First, Middle, Last)   |   |                                     |   |                                   |             | 2. Date of Dea<br>Month                 | ath<br>Day      | Yeer                  | 3. Time of Death                                 |
|                          | Physicia<br>/Medic   | al               | Allan Donald Mc  |   |                                     |   |                                   |             | July 7,                                 |                 |                       | 6:01 PM M  |
|                          | Examin   |                  | 4a. Fecility Name (If not institution, give s  | treet and number)   |                                     | ,   | n, or Location                    | of Death    |   |                 | nty of Deeth          |  |
|                          |  |                  | 211 Ingleside A  |   |                                     | Baltim  |                                   | 24 Usa      |   |                 | timor                 |  |
|                          | Funeral<br>Director  |                  | 5. Social Security Number 6. Sex 216–38–2699   |   | s. last birthday)<br>5 Yrs.         | If Under 1 You<br>Months Da                       |                                   | Min.        | 8. Date of Birt<br>(Month, De<br>Feb 6, | , Year)<br>1941 | Mar                   | hplece (State or Foreign<br>untry)<br>y Land     |
| T                        |  |                  | Usuel Residence of Decedent  |   |                                     | 1   |                                   |             |   |                 |                       |  |
| i d                      | how #  |                  | 10a. State 10b. County   |   | City, Town or Lo                    |   |                                   |             |   |                 |                       | 10d. Inside City Limits                          |
| 1                        | la-f.  | cto              | MD Baltimore   |   | Baltimo                             | re  |                                   |             |   |                 |                       | 1 Yes 2 No                                       |
| i                        | 3a or 28   | Funeral Director | 10e. Street and Number<br>211 Ingleside Av   | enue  |                                     | 10f. Zip Coo                                      | 21228                             |             |   | 10g. Citizen o  | USA                   | untry?   |
| 900                      | Em (   | ner              | 11. Marital Status   | 12. Was Decedent Ever in<br>Armed Forces?                                     | U.S. 13.                            | Was Decedent                                      | of Hispanic Or<br>Cuban, Mexica   | rigin? (Spe | ecify Yes or No<br>Rican, etc.)         | 14. R           | lace - Amei           | rican Indian,                                    |
| 0                        | or ite   | F                | 1 ☐ Never Married 2 ☐ Married  | 1 ☐ Yes 2 TNo<br>If Yes, Give   |                                     | 1 ☐ Yes 2 🔯                                       |                                   |             | , ,                                     | Spec            |                       | hite   |
| 3                        | urel'.   | d by             | 3 Widowed 4 Divorced   | Year or Dates:  |                                     |   |                                   |             | unk                                     |                 |                       |  |
| ה ה<br>ה                 | "natu  | Completed        | 15. Decedent's Educ<br>(Specify only highest grade   | cation<br>completed)  | (Give                               | dent's Usual O<br>kind of work d<br>DO NOT use re | one during mos                    | st of work  |   | 16b. Kind of    | Business/I            | Industry   |
| 7                        | han M  | m<br>m           | Elementary/Secondary (0-12)  | College (1-4or 5+)  | me.                                 | DO NOT USE TO                                     | sured)                            |             |   | const           | truct                 | ion  |
| 7                        | Hygie<br>ther t  |                  | 17. Father's Name (First, Middle, Last)  | U   |                                     |   | 18. Moth                          | er's Name   | (First, Middle,                         |                 |                       |  |
| yland                    | ked of   | To Be            | Allan Donald McCa  | nn Sr   |                                     |   | Si1                               | vetta       | a Parse                                 | n               |                       |  |
| Mary                     | th and N   |                  | 19a. Informant's Name/Relationship (Ty),<br>Elvera McCann/spo  |   |                                     |   |                                   |             | al Route Number                         |                 | vn, State, Z<br>21228 |  |
| lore,                    | permit. Pages 1 and 2 should be tiled within 72 hours surer destri with the waryand Department of Health and Mential Hygiene. Department of Health and Mential Hygiene. Inportant: If then 27 is marked other than "naturel", or itema 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at ODGs. |                  | 20a. Method of Disposition 1 Burial 2 Cremation 3 R  |   | p. Place of Dispo<br>cemetery, cre- | osition (Name of<br>matory or other               |                                   | С           | Date                                    | 20c. Locatio    | n - City or 1         | Town, Stete                                      |
| Baltimor                 | permit. Pa<br>Departme<br>important<br>any injury<br>once.   |                  | 21. Signature of Ronal Service License   | Wady, Direct  |                                     |   | -                                 |             | 655 W.                                  | Balti           | more                  | Street   |
|                          | 70 2 4 Q   |                  | 23a. Per 1. Enter the disease, or compli   | Jul   |                                     | altimor   |                                   |             |   | roat            |                       | Approximate                                      |
|                          | nysician<br>/Medical<br>Examiner   |                  | shock, or heart failure. List only or<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | Due to (or as e lons  | ragee                               | 1 0   | ince                              |             |   |                 |                       | Interval Between inset and Deut                  |
| A                        | 8 13   | Examiner         | Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury    | Due to (or as a cons  | sequence of):                       |   |                                   |             |   |                 |                       | _  |
| -                        | icate be executed<br>physician and<br>s the burial-transit   | ical             | that initiated events resulting in death) Last   | Due to (or as a cons  | equence of):                        | 44.0.50.00  |                                   |             |   |                 |                       |  |
| ). Box 68                | ath certif<br>ttending<br>or use as  | Physician/Med    | in the past 12 months?   | 3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of             | etel death 3[                       | □Ectopic pregn                                    |                                   |             |   | 1               | Date of deli<br>Month | ivery<br>Day Year                                |
| ت<br>5                   | at the   | Phy              | 9 Unknown  | ataibudine to death but eat   | rooulting in the                    | and arbitrar and                                  | o awaa ia Bad                     |             | 22e Did t                               | obacco use co   | ontribute to          | the cause of death?                              |
| rds,                     | w requires that the de<br>been signed by the a<br>should be detached t   | b                | Part II. Other significant conditions con  | nthouting to death but not  |                                     | andenying caus                                    | e given is ran                    | ·           |   | res 2 □ No      |                       | 1  |
| Records,                 | The law requ   | Completed        |  |   |                                     |   |                                   |             | 24a. Was<br>auto<br>perio<br>1 🗆 Yes    |                 | prior to death?       | stopsy findings available completion of cause of |
|                          |  | 0                | 25. Was case referred to medical   |   |                                     |   | 26. Plac                          | e of Deatl  | h (Check only o                         |                 |                       | 25,70  |
|                          | Physician:<br>rthis certifica<br>ral director, i   | 0                | examiner? 1 Tes 2 Vo   | Hospital:   | ER/Outpatie                         | nt 3 DOA  | Other: 4 N                        | lursing Ho  | me 5 Resi                               | dence 6 🗆 0     | Other (Spec           | cify)  |
|                          | ing<br>Afte<br>une   | tion; T          | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Injury<br>(Month, Day Yeer                                       | 28b. Time of Injury                 | of 28c.   | Injury at<br>Work?<br>1 ☐ Yes 2 ☐ |             | 28d. Describe                           | now injury occ  | curred                |  |
| $\overline{\overline{}}$ | il or Attending<br>after death.<br>Director: After<br>I in by the fune   | Certification;   | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of Injury - A<br>building, etc. (Spe                               | t home, farm, st<br>ecify)          | reet, factory, of                                 | ffice                             |             | 28f. Location (.<br>City or To          |                 | mber or Ru            | ural Route Number,                               |
|                          | To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in bi  | edical Co        |  | sician: To the best of my<br>ner: On the basis of exam<br>and granner stated. |                                     |   |                                   |             |   |                 |                       |  |
|                          | o the<br>ithin<br>o the  | Me               | 29b. Signature and little of contifier   | 1   |                                     | 29c. L  | cense number                      |             |   | 29d. Date sig   | ned (Monti            | h, Day, Year)                                    |
|                          | ⊬≯≓ö   |                  | 1 len /2 Nor   | mely MD   |                                     |   | D185                              | -87         |   | JUL             | 13                    | 2006   |
|                          |  |                  | 30 Name an address of person who co  | omplet scause of death (  | 7 ton                               | Print)<br>Ave                                     | Balı                              | lino        | re IN                                   | <i>ا</i> لم     | 212                   | 206  |
|                          | St<br>Regist   | ate<br>rar       | 31. Date filed (Month, Day, Year)  | 32. Registrar's S   | gnature                             | de  |                                   |             | ,                                       | in a second     |                       |  |

|                  |  |                  | For<br>Stata<br>Registrar  | State of   | f Maryla                    |                   | artment of H                              |                        | Mental I          | Hygier<br>Reg. N    | 21116                       | 22                                    | 752       |  |  |
|------------------|--|------------------|--|--|-----------------------------|-------------------|---|------------------------|-------------------|---------------------|-----------------------------|---------------------------------------|-----------|--|--|
|                  |  |                  | Decedent's Name (First, Middle, I  | .ast)  |                             |                   |   |                        | 2. Date of        |                     |                             | 3. Time of                            | Death     |  |  |
|                  | Physici  | an               |  | DORO   | THY V                       | IRGINI            | A MOLES                                   | WORTH                  | JULY              |                     | Day Year                    | 8:20                                  |           |  |  |
|                  | /Medic   |                  | 4a. Facility Name (If not institution, o   |  |                             |                   | 4b. City, Town, or                        |                        |                   |                     | 2006<br>4c. County of Dea   |                                       | _Р        |  |  |
| П                | Examin   | er               |  |  | ,,,,,,                      |                   |   |                        | ****              |                     |                             |                                       |           |  |  |
|                  |  |                  | 58 GEORGE ST. 5. Social Security Number 6.   | Sex  | 7. Age (In vi               | s. last birthday  |   | YTOWN If Under 24 Hr   | s. 8. Date of     | Birth               | CARRO:                      |                                       | r Foreign |  |  |
|                  | Funeral<br>Director  |                  |  | 1□M 2⊠F  |                             | 3.7 Yrs.          | Months Days                               | Hours Mir              | 1. (Month         | Day, Yea            | ay, Year) Country)          |                                       |           |  |  |
|                  |  |                  | 219-12-1516   Usual Residence of Decedent  |  |                             | ) /               | 1   |                        | 9/1               | 5/19                | 13 MAR                      | RYLAND                                |           |  |  |
|                  | land ow  |                  | 10a. State 10b. County   |  | 10c.                        | City, Town or L   | ocation                                   |                        |                   |                     |                             | 10d. Inside Cit                       | y Limits  |  |  |
|                  | Mary   | ō                | MD CARR  | OLL  |                             | TANEY             | TOWN                                      |                        |                   |                     |                             | 1 <b>X</b> Yes                        | 2 🗌 No    |  |  |
|                  | 28a-   | ec               | 10e. Street and Number   |  |                             |                   | 10f. Zip Code                             |                        |                   | 100.0               | Citizen of What Co          | ountry?                               |           |  |  |
|                  | with a or  | Funeral Director |  |  |                             |                   |   | 707                    |                   |                     |                             |                                       |           |  |  |
|                  | eath   | era              | 58 George St.  | 12. Was Dec  | edent Ever in               | 11.5 13           |   | 787                    | Specify Ves or    | No-                 | USA<br>14. Race - Ame       | nican Indian                          |           |  |  |
|                  | iten<br>iten   | ů.               | 1 Never Married 2 Married  | Armed Fo   | orces?                      | 0.5.              | Was Decedent of H<br>If Yes, specify Cuba | in, Mexican, Pue       | nto Rican, etc.   | )                   | Black, Whit                 |                                       |           |  |  |
| 5                | hours after death with the Maryland<br>lurel', or Iteme 23a or 28a-f ehow<br>at Exeminational be notified at   | by               | 3 X Widowed 4 □ Divorced   | If Yes, Gir<br>Year or D   | ve                          |                   | 1 ☐ Yes 2 ☒ No                            | Specify:               |                   |                     | Specify: W                  | HITE                                  |           |  |  |
| 21215-0036       | hou  |                  | 15. Decedent's   |  |                             | 16a Dece          | dent's Usual Occup                        | ation                  |                   | 16h                 | Kind of Business            | /Industry                             |           |  |  |
| Ċ                | within 72<br>ene.<br>then "nai   | iet              | (Specify only highest of   | rade completed)  |                             | (Give             | kind of work done of DO NOT use retired   | during most of w       | orking            | 100.                | Tring of Business           | moustry                               |           |  |  |
| 7                | with<br>Bne.<br>ther   | Completed        | Elementary/Secondary (0-12)<br>12  | College (  | 1-4or 5+)                   |                   | HOUSE                                     |                        |                   | н                   | OMEMAKE                     | TD.                                   |           |  |  |
|                  | be filed within 72 hours after death with the Marylar ital Hyglene. Id other then "naturel", or iteme 23a or 28a-f ehow other, its Medical Examinaterman its natified at |                  | 17. Father's Name (First, Middle, La   | st)  |                             |                   |   | 18. Mother's Na        | ame (First, Mic   |                     |                             |                                       |           |  |  |
| Maryland         | d be<br>ontal  | ) Be             |  | JONATHA  | N MON                       | NROE O            | WINGS                                     |                        |                   |                     | DEVILE                      | BISS                                  |           |  |  |
| 2                | should be<br>nd Menta<br>marked  | ဥ                | 19a. Informant's Name/Relationship   |  |                             |                   | ng Address (Street a                      |                        |                   |                     |                             |                                       |           |  |  |
| <u>s</u>         | S 6 5 9  |                  |  |  | CON                         |                   | ,   |                        |                   |                     |                             | zip Coαθ)                             |           |  |  |
|                  | 1 and<br>Health<br>tem 27<br>other tr  |                  | PAUL A. MOLESW  20a. Method of Disposition   | ORTH .   | - SON                       |                   | EORGE ST                                  | · , TANE               | Date              |                     | Location - City or          | Town State                            |           |  |  |
| altimore,        | Pages<br>nent of I<br>int: if it   |                  | 1 X Burial 2 ☐ Cremation 3   |  | State                       | cemetery, cre     | matory`or other plac                      |                        |                   |                     |                             |                                       |           |  |  |
|                  | Pages<br>tment of<br>tant: if il   |                  | 4 □Donation 5 □ Other (Spec  |  | EVE                         |                   | MEM.GA                                    |                        |                   | -                   |                             |                                       |           |  |  |
| Rai              | permit. Pages<br>Depertment of<br>Important: if ii<br>eny injury or o  |                  | 21. Cignature Fine al Service Lic  | ensee  |                             | 1,000             | 2. Name and Addres                        |                        |                   |                     |                             |                                       |           |  |  |
| _                | 40 E 9 d   |                  | ( NOW I  |  |                             |                   | 54 E. MA                                  |                        |                   |                     | STER, M                     | D 2115                                | 7         |  |  |
|                  |  |                  | 23a. Part1. Enter the disease, or co<br>shock, or hearf failure. List on           | mplications that on the control on the cause of the cause on the cause of the cause of the cause on the cause of the cause | caused the de<br>each line. | eath. Do not en   | ter the mode of dyin                      | g, such as cardia      | ac or respirator  | ry arrest,          |                             | Approximate<br>Interval Bety          | veen      |  |  |
|                  | Physician  |                  | Immediate Cause (Final disease or condition  |  | ~                           | MO CZO            | Light Fo                                  | facte                  |                   |                     | 4                           | Conset and E                          | eath.     |  |  |
|                  | /Medical   |                  | resulting in death)  | Due to   | (or as a cons               |                   |   |                        |                   |                     |                             |                                       |           |  |  |
|                  | Examiner   |                  | Conventially list conditions   | h  |                             |                   |   |                        |                   |                     |                             |                                       |           |  |  |
| 7                | ~ ~  | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to   | (or as a cons-              | equence of):      |   |                        |                   |                     |                             |                                       |           |  |  |
|                  | be executed<br>icien and<br>burial-transit   | Examin           | Cause (Disease or injury that initiated events                                     | c  |                             |                   |   |                        |                   |                     |                             |                                       |           |  |  |
| Ď                | exe<br>en a  |                  | resulting in death) Last   | Due to   | (or as a cons               | equence of):      |   |                        |                   |                     |                             |                                       |           |  |  |
| 09/8             | icate be executed<br>physicien and<br>s the burial-transit   | dical            |  | d  |                             |                   |   |                        |                   |                     |                             |                                       |           |  |  |
| 0                | tifica<br>ng ph<br>as t  | Med              | .= ===   |  |                             |                   |   |                        |                   |                     |                             |                                       |           |  |  |
| ROX              | death certifi<br>e attending I<br>id for use as  | by Physician/Me  | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, ou  | tcome of preg               |                   | Ectopic pregnancy                         |                        |                   |                     | 23d. Date of del            | livery                                |           |  |  |
|                  | deat<br>e att  | Cla              | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 4☐Pregr  | nant at time of             |                   | Other (specify)                           |                        |                   | _ ]]                | Month                       | Day Y                                 | 'ear      |  |  |
| Ö                | res that the de<br>signed by the a<br>be detached f  | hys              | 9 ☐ Unknown  | 9□ Unkn  | own                         |                   | -0.01.1                                   |                        |                   |                     | 2                           | U.S                                   |           |  |  |
|                  | law requires that the<br>as been signed by th<br>2 should be detache   | Ϋ́               | Part II. Other significant conditions  | contributing to d  | eath but not r              | esulting in the L | inderlying cause give                     | en in Part I.          | 23e. D            | id tobacco          | o use contribute to         | the cause of de                       | ath?      |  |  |
| <b>Records</b> , | w require<br>been sig<br>should b  |                  |  | mperti   | a oxu                       |                   |   |                        | 1                 | ☐ Yes               | 2 <b>□</b> ₩6 3 □ Pr        | obably 4 DU                           | nknown    |  |  |
| ၀                | w re   | Completed        |  |  |                             |                   |   |                        | 24a. V            | √asan               | 24b. Were au                | utopsy findings a                     | vailable  |  |  |
| e<br>T           | The lav  | μŽ               |  |  |                             |                   |   | <del></del>            | a<br>p            | utopsy<br>erformed2 | death?                      | utopsy findings a<br>completion of ca | use of    |  |  |
| Vitai            |  | ပိ               | 25. Was case referred to medical   | Martine II-  | 1000 III                    |                   |   |                        | 1 □ Y∈            |                     | Vo 1 ☐ Yes                  | 2 □ No                                |           |  |  |
| 5                | Physicien:<br>rthis certific<br>ral director,  | o Be             | examiner?  | Hospital: 1 🔲  |                             | Orno · ·          | othe Othe                                 | 26. Place of De        |                   |                     |                             |                                       |           |  |  |
| Ö                | Phy<br>ral o   | $\vdash$         | 27. Manner of Death  |  |                             | ER/Outpatie       | IL SLI DOA                                | 4 🗀 Nursing            |                   |                     | 6 ☐Other (Speciary occurred | cify)                                 |           |  |  |
|                  | Alter<br>fune  | Pol              | 1 ☐Natural 5 ☐ Pending   |  | of Injury<br>th, Day Year)  | Injury            | Work                                      | Yes 2 □ No             | 200. 2000         | DO HOW IN           | july occurred               |                                       |           |  |  |
| <u>s</u>         | deeth<br>ttor:   | Ical             | 2 Accident investigat 3 Suicide 6 Could not  | be 200 Gleen   | of Injune At                | home form at      | reet, factory, office                     | 163 2 110              | 20f Location      | n (Ctanat           | and Number or Ru            |                                       |           |  |  |
| Division         | or A<br>offer<br>Direction by  | Certification;   | 4 ☐ Homicide determine   | build  | ing, etc. (Spe              | cify)             | reet, ractory, office                     |                        | City or           | Town, Sta           | are)                        | TIST MODIE INDIT                      | 167,      |  |  |
| _                | To the Hospital or Attending within 24 hours effer deeth.  To the Funerel Director: Alter completely filled in by the fune   |                  | 29a Certifier 1 Certifying   | Physician To the   | boot of must                | noudodas dans     | h securred at the tim                     | na Objeta nasodna si s | 20 Opt # 400 P    | the state of        | nas allega seksalari se     | anara d                               |           |  |  |
|                  | Hoe<br>24 ho<br>Fun<br>fely  | lica             | (Check only 2 Medical Ex   | aminer: On the b   | asis of exami               | nation and/or in  | vestigation, in my of                     | pinion, death occ      | curred at the tir | ne, date a          | ind place, and due          | to the cause(s)                       |           |  |  |
|                  | ithin i  | Medicai          | 29b. Signature and title of certifier  | / /  | noi sidibu.                 |                   | 29c. License                              | number                 |                   | 29d F               | Date signed (Monti          | h. Dav. Yearl                         |           |  |  |
|                  | F 3 F 8  | 9                |  | w/V.   |                             | 1                 | 1   | D 4361                 | 13                |                     | 7-19                        |                                       |           |  |  |
|                  | /  |                  |  |  | ,,,,,                       |                   |   |                        | . –               |                     | -2- 1-(                     | φ                                     |           |  |  |
|                  | 5  |                  | 30. Name and address of person wh  |  |                             |                   | Print)                                    | 10                     | The               | 4000                | in ins                      | 2178                                  | a         |  |  |
|                  | 0  |                  | 31. Date filed (Month, Day, Year)  |  | PTG<br>Registrar's Sig      | nature ,          | , ,,,,,,,                                 |                        |                   |                     | ,                           |                                       |           |  |  |
|                  | Sta<br>Registr   |                  | disa   |  | S. Oly                      | 2.0               | 1 -                                       |                        |                   |                     |                             |                                       |           |  |  |
|                  | J. J. J.   |                  |  | 2006   | 10.0.10                     | 15-1              | HOAT!                                     |                        |                   |                     |                             |                                       |           |  |  |

06-04968 Please Type or Print in Black Indelible Ink Timothy L. Miller State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death Medical Examiner Month Day July 10, 2006 Timothy Miller 2110 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death Sinai Hospital Baltimore N/A Funeral 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Foreign Country) MD Months Days Hours 215-74-3577 XXM 41 2 **0**7/15/1964 Usual Residence of Decedent 10a. State 10c City, Town or Location 10d Inside City Limits is 23a or 28a-f show ; MD N/A Baltimore Director 1 X Yes 2 No 10e Street and Number 10g Citizen of What Country 838 North Fulton Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or 14. Race - American Indian, Black, Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes 4 X Divorced 3 Widowed If Yes, Give Year 1 Yes 2 X No specify ģ Specify Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) I and 2 should be filed within 72 is marked other than ' 21215-0036 and Mental Hygiene Presser Dry Cleaners 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Funjortant: If item 27 is marked injury or other traumatic event. æ <u>Willie Miller</u> Hattie Miller ၀ 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M <u>Hattie</u> Miller North Fulton Ave., Baltimore,  $_{\rm Md}$ 2121720a. Method of Disposition 3altimore, 20b. Place of Disposition (Name of cemetery crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Pages Donation 5 Other Specify 7/18/2006 \_Baltimore,Md 21 Signarure of Funeral Service Lice Estep Brothers Funeral Home 1300 Eutaw Place, Baltimore, 21217 Enter the **Physician** sease, or complications that caused the Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line Approximate Interval /Medical Between Onset and Immediate Cause (Final disease Complications of sepsis Death Examiner condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). and Physician/Medical X UNPENDED attending physician or use as the burial #23a,PII,27,perME,g861,11/14/06 TT Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death Ectopic pregnancy past 12 months? Month Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. 23e. Did tobacco use contribute to the cause of death? Š Diabetes mellitus; hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? ✔ Yes 2 1 🗸 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 / Inpatient this Other, 1 🗸 Yes ER/Outpatient 3 ဥ DOA Nursing Home 5 Residence 6 Other 28a Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29h ure and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 13, 2006 me and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State

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Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

| 2006 | 2 | 2 | 7 | 5 | Server and |
|------|---|---|---|---|------------|
|------|---|---|---|---|------------|

|  |                        | 1- For State<br>Registrar   |  | Cer  | tificate of              | Death                                 |                    |                                   | Reg. No.                        | 400             |  |
|--|------------------------|---|--|--|--------------------------|---------------------------------------|--------------------|-----------------------------------|---------------------------------|-----------------|--|
| Physicia   |                        | Decedent's Name (First, Midd                                      | dle,Last)                                  |  |                          |                                       |                    | Date of D     Month               | eath<br>Day                     | Year            | Time of Death  |
| /ledical Exami   |                        | REUBIN T.S  | . MCFADDI                                  | EN   |                          |                                       |                    | July 16,                          | 2006                            | . Gai           | 1227 hrs   |
|  |                        | 4a. Facility Name (if not institution  Johns Hopkins Hospi        | on, give street and nun                    |  | 4                        | 4b. City, Town, o                     |                    | of Death                          | 4c. C                           | ounty of Dead   | th   |
|  |                        | Social Security Number  |  | 7. Age (In yrs. Ia   | est hirthday)            | If Under 1 Ye                         |                    | er 24Hrs 8. Date of               | Birth (MM/DE                    |                 | irthplace (State or                                  |
| Funeral  |                        | ·   |  | . Age (III yrs. Ia   | ist birthday)            | Months Da                             |                    | Min                               | `                               | Fore            | ign  |
| Director   | - 1                    | 215 92 5601   | 1 XM 2 F                                   | 2  | 7 Yrs                    |                                       |                    | SEPT                              | 1.13.                           | <u> 1978 °</u>  | ountry) MD.  |
|  |                        | Usual Residence of Decedent                                       |  |  |                          |                                       |                    |                                   | -17                             |                 |  |
| any  |                        | 10a State 10b. County   |  | 10c City,  | Town or Locati           | on                                    |                    |                                   |                                 |                 | 10d Inside City Limits                               |
| nd<br>how  | اب                     | MD DA   | LTIMORE                                    |  | OUT NO                   | S MIL                                 | r.s                |                                   |                                 |                 | 1 Yes 2 N  |
| vlaryland<br>28a-f show<br>d at once.  | 윙                      | MD BA  10e. Street and Number                                     | HILLIONE                                   |  | OMILIN                   | 10f. Zip Code                         |                    |                                   | 10g. Citizer                    | n of What Co    | untry?   |
| th the Maryland<br>23a or 28a-f sho<br>notified at once.   | Director               | 277   | DE GERGE                                   | -  |                          |                                       | 211                | 17                                |                                 | USA             |  |
| th th  |                        |   | RE CIRCL                                   | Edent Ever in U.   | S 13 Ma                  | s Decedent of L                       |                    | in? ( Specify Yes or              | No. I 14                        |                 | erican Indian, Black,                                |
| t be   | Funeral                | 11. Marital Status 1 Never Married 2                              | Married Armed For                          |  |                          |                                       |                    | Puerto Rican, etc.)               | 110                             | White, etc.     | STOUTH MACH, DICON,                                  |
| or it  | ᆵ                      |   | 1 Yes                                      | 2 X No   |                          |                                       |                    |                                   |                                 |                 | LACK   |
| after  | à                      |   | vorced If Yes, Give Year<br>or Dates:      |  |                          | Yes 2X N                              |                    | <del> </del>                      |                                 |                 |  |
| hours after death with the Maryland<br>'natural', or items 23a or 28a-f sh<br>Examiner must be notified at once  |                        | 15. Decedent's Education (Sp.                                     |  |  |                          | it's Usual Occup<br>ost of working li |                    | kind of work done<br>use retired) | 16b. Kin                        | d of Business   | s/Industry   |
| 2 3 =  | Completed              | Elementary/Secondary (0-12  | ) College (1-                              | 4 or 5+)   |                          |                                       |                    |                                   |                                 |                 |  |
| 15-0036<br>filed within 72<br>of Hygiene<br>ed other than "<br>t, the Medical  | 립                      | 10TH  |  |  | FRY (                    | COOK                                  |                    |                                   |                                 | NDY"S           |  |
| 5-0<br>iled w<br>Hygie<br>I othe   | ડ                      | 17 Father's Name (First, Middle                                   | e, Last)                                   | -  |                          |                                       |                    | 's Name (First, Middl             | e, Maiden Su                    | irname)         |  |
| 21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medics  | Be                     | BERNARD MC  | FADDEN S                                   | R.   |                          |                                       | GRA                | CE BELL                           |                                 |                 |  |
| Me ma  | 70                     | 19a, Informant's Name/Relation                                    |  |  |                          |                                       |                    | nber or Rural Route               |                                 |                 |  |
| MD 2<br>id 2 shou<br>alth and M<br>m 27 is n   |                        | GRACE WILLIA  | MS (moth                                   | er)  | 277                      | CEDAR                                 | ARMAR              | RE CIRCLI                         | E OWI                           | NGSMI           | LLS,MD.21  |
| e, M<br>I and 2<br>Health<br>item 2  |                        | 20a. Method of Disposition  |  |  |                          | ition (Name of o                      | cemetery,          | Date                              | 20c. Lo                         | cation - City o | or Town, State                                       |
| Baltimore,<br>permit. Pages I ar<br>Department of Hee<br>Important: If ite   |                        | 1 X Burial 2 Cremation  | on 3 Removal fro                           |  | crematory or ot          |                                       | שמ                 | JULY 26                           | 2006                            | אדתי            | O MD   |
| iment ment tant  |                        | 4 Donation 5 Other S  |  | VI   |                          |                                       |                    |                                   |                                 |                 |  |
| Baltimo<br>permit. Page<br>Department o<br>Important:<br>injury or oth   |                        | 21. Signature of Funeral Service                                  | e Licensee                                 |  | 22 C                     | ALVIN .                               | B. SC              | RUGGS FU                          | JNERA                           | L HOM           | E  |
| <b>m</b> 90 5 5 5  |                        | Dunadu  | re V. sc                                   | MAGA   | 11/                      | 112 F                                 | DRFS               | TO MOTE                           | RAT.T                           | O MD            | . 21212  |
| Physician  |                        | 23a. Part I. Enter the disease, of failure. List only one caus    | or complications that ca<br>e on each line | used the death.  | . Do not enter t         | he mode of dyin                       | ıg, such as c      | ardiac or respiratory             | arrest, shock                   | , or heart      | Approximate Interval<br>Between Onset and            |
| /Medical   | 13                     | Immediate Cause (Final diseas                                     | Maultinia Cu                               | nshot Woun   | ids                      |                                       |                    |                                   |                                 |                 | Death  |
| Examiner   |                        | or condition resulting in death)                                  | Due to (or as a                            |  |                          |                                       |                    |                                   |                                 |                 |  |
|  |                        | Sequentially list conditions,                                     | b  |  |                          |                                       |                    |                                   |                                 |                 | 40   |
|  | Jer                    | if any, leading to immediate                                      | Due to (or as a                            | consequence o  | f):                      |                                       |                    |                                   |                                 |                 |  |
|  | Ē                      | cause. Enter Underlying Caus<br>(Disease or injury that initiated | C  |  |                          |                                       |                    |                                   |                                 |                 |  |
| l d is   | Examiner               | events resulting in death) Last                                   | Due to (or as a                            | consequence o  | T):                      |                                       |                    |                                   |                                 |                 |  |
| and and train  |                        |   | d  |  | -                        |                                       |                    | _                                 |                                 |                 |  |
| be ex<br>ician   | gic                    | UNPENDED  | AMENDED                                    |  |                          |                                       |                    |                                   |                                 |                 |  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in prepared in the formeral director, page 2 should be detached for use as the burial - transit | Physician/Medical      | IF FEMALE:<br>23b. Was decedent pregnant in                       | Alexa                                      | outcome of preg  |                          |                                       |                    |                                   |                                 | Date of delive  | *  |
| 68<br>ertifi<br>ding<br>e as t   | an                     | past 12 months?   | 1  | irth<br>ant at time of de  | - de                     | Acc. Godin                            | 3 Ectopi           | c pregnancy                       | M                               | Ionth           | Day Year   |
| Box 68 ne death certi the attendin   | Sic                    | 1 Yes 2 No 9 U  | nknown 9 Unkno                             |  | eath 5 O                 | ther (Specify)                        |                    |                                   |                                 |                 |  |
| ne de  | , Š                    | Part II. Other significant cond                                   |  |  | oculting in the          | endorluina eque                       | o given in Pr      | art 23e Di                        | id tobacco us                   | e contribute t  | to the cause of death?                               |
| Division of Vital Records, P.O. rat or Attending Physician: The law requires that the restrict death.  The intervent of the restriction of the restriction of the former of the rate of the former of the rate of the former of director, page 2 should be drackly the former of the record.   |                        | Part II. Other significant cond                                   | intions contributing to                    | death but not n  | esulting in the i        | underlying caus                       | e given in re      |                                   |                                 | No 3 Pro        |  |
| ires t<br>sign<br>lbe o  | 9                      |   |  |  |                          |                                       |                    |                                   |                                 |                 |  |
| ords, P.C<br>w requires that<br>is been signed!<br>should be deta  | Completed by           |   |  |  |                          |                                       |                    | 24a. W                            | as an<br>Itopsy                 |                 | autopsy findings available<br>completion of cause of |
| CO<br>law<br>e 2 s   | 밑                      |   |  |  |                          |                                       |                    | pe                                | erformed?                       | death?          | ,  |
| in of Vital Recoling Physician: The law After this certificate has funeral director, page 2 sl   | 8                      |   |  |  |                          | 26 DI                                 | as of Dooth        | (Check only one)                  | ss Z NU                         | 1 🗸             | res 2 No   |
| certi<br>certi   | l &                    | 25. Was case referred to medic examiner?                          | (Invested)                                 |  |                          |                                       | Other <sub>4</sub> | Nursing Home 5                    | Residenc                        | ce 6 Oth        |  |
| hysi al dir  | ₽                      | 1 Yes 2 No  |  | npatient 2 🗸   |                          |                                       |                    |                                   | be how injury                   |                 | iei.   |
| of<br>Ing P<br>After<br>unera  | چ ا                    | 27. Manner of Death   | 28a. Date<br>Jul 16, 2                     | of Injury<br>Day Year)   | 28b. Time of<br>1200 hrs | Injury 28c. II                        | njury at Work      | <ul> <li>Subject s</li> </ul>     |                                 | occurred        |  |
| on<br>tendi  | 읉                      |   | nding Jul 16, 2                            | .000   | 1200 1113                | 1                                     | Yes 2              | No .                              |                                 |                 |  |
| ivision or Attendather death Director:   | 👸                      |   | ould not be 28e. Place                     | e of Injury - At h   | ome, farm, stre          | et, factory, offic                    | e building, e      |                                   |                                 | Number or F     | Rural Route Number, Cit                              |
| Div<br>talo<br>al D  | Έ                      |   |  | Local Stre   | et                       |                                       |                    | 900 block                         | n, State)<br>c of <b>N</b> . Co | llington Av     | venue, Baltimore, I                                  |
| Division of Vital Rec<br>To the Hospital or Attending Physician: The<br>within 24 hours after death.<br>To the Funeral Director: After this certificate<br>completely filled in by the funeral director, page  | Medical Certification: | 29a Certifier   | Physician: To the bes                      | t of my knowled  | tae death occu           | rred at the time.                     | date and pl        | ace, and due to the o             | ause(s) and                     | manner as st    | arted.   |
| the III 12/2 lin 2/4 lhe F   | ica<br>ica             | (Check only one) 2 Medical Ex                                     | kaminer: On the basis                      | of examination a   | and/or investiga         | ation, in my opin                     | ion, death o       | ccurred at the time, d            | ate and place                   | and due to      | the cause(s)   |
| To T<br>Com  | led                    |   | and manner s                               | tated  |                          | 29c Lice                              | ense number        |                                   | 29d Da                          | ate signed (N   | Nonth, Day, Year)                                    |
|  | ≥                      | 29b. Signature and this of cert                                   |  | ١  |                          |                                       |                    |                                   | 200 20                          | 7               | 1  |
|  |                        | XIII  | 10/10                                      | 1  |                          | 0.0                                   | C.M.E.             |                                   | ,                               | 1//16           | 106  |
|  |                        | 30 Name and address of pers                                       |  |  |                          |                                       |                    |                                   |                                 |                 |  |
| .7   | 1                      | Susan Hogan MD.   | Assistant Medic                            |  |                          | nn Street, B                          | altimore,          | MD 21201                          |                                 |                 |  |
|  | State                  | 31. Date filed (Month, Day, Yea                                   |  | istçar's Signat  | ure                      |                                       |                    |                                   |                                 |                 |  |
| Regi   |                        | 1111 0  | 0 2006                                     | Pagine   | 16 R                     | and I                                 |                    |                                   |                                 |                 |  |
|  |                        |   | 8  | The second secon | ORIGINA                  | 1                                     |                    |                                   |                                 |                 |  |
| DHMH 17 Rev 1  | 1200 I                 |   |  |  | OKIOINA                  | ٦L.                                   |                    |                                   |                                 |                 |  |

|                                     |  |                  | State of Manyland / Der  | partment of Health and Menta   |   | ~ ~ ~ ~ ~ **   |
|-------------------------------------|--|------------------|--|--|---|--|
|                                     |  | •                | , roi  | ertificate of Death  | Reg. No. 006  | 22755  |
|                                     |  |                  | Decedent's Name (First, Middle, Last)  | 2. Dat   | e of Death<br>nth Day Year                          | 3. Time of Death                                     |
|                                     | Physicia<br>/Medic   |                  | RICHARD L. OWENS SR.   | 70   | LY 17 200   | 6 6:00 AM  |
|                                     | Examin   |                  | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death   | 4c. County of De                                    |  |
|                                     |  |                  | NOTTHWEST HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda  | RANDALLSTOWN  If Under 1 Year If Under 24 Hrs. 8, Dat  |   |  |
|                                     | Funeral<br>Director  |                  | 216-56-2739 1 MM 2□F 53 Yrs.   | Months Days Hours Min. (Mo   | /13/1953 M  | inthplace (State or Foreign<br>Country)<br>ARYLAND   |
|                                     | D.   |                  | Usual Residence of Decedent  |  | 7 107 1201  |  |
|                                     | arylar<br>show   | 2                | 10a. State 10b. County 10c. City, Town or BALTIMORE  | RANDALLSTOWN   |   | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No               |
|                                     | the M  | ecto             | 10e. Street and Number   | 10f. Zip Code  | 10g. Citizen of What C                              |  |
|                                     | within 72 hours after deeth with the Maryland<br>ene.<br>Than "natural", or Items 23a or 28a-f show<br>fre Medical Examinar must be notitled at  | Funeral Director | 4109 SPRINGSLEIGH ROAD   | 21133  | USA   | , out tilly .  |
|                                     | ms 2   | nera             | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?   | . Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, | s or No- 14. Race - Arr                             |  |
| 9                                   | or its   |                  | 1 Never Married 2 Married 17 Yes 2 No ARMY   | 1 ☐ Yes 2 XNo Specify:   |   | BLACK  |
| Ö                                   | hours<br>tural',   | d by             | 3 Wildowed 4 Divorced Year or Dates:   | edent's Usual Occupation   | 16b. Kind of Busines                                |  |
| 5                                   | in 72<br>"nal" r   | olete            | (Specify only highest grade completed) (Gir  | re kind of work done during most of working DD NDT use retired) LROAD CONDUCTOR              | CSX RAI   | -  |
| 212                                 | d with<br>giene.   | Completed        | Elementary/Secondary (0-12) College (1-4or 5+) RA  | LROAD CONDUCTOR  | CSA RAI   | LKOAD  |
| ם                                   | be filed<br>ntal Hygi<br>of other<br>event, I  | Bec              | 17. Father's Name (First, Middle, Last)  | 18. Mother's Name (First, MARV .TANE   | Middle, Maiden Surname) C NORRIS                    |  |
| <u>ya</u>                           | should be filed within 72 hours after deeth with the Marylan of Menutal Hygiens a marked other than "natural", or flems 23a or 28a-f show marked other than "natural", or flems 23a or 28a-f show marked other than "natural" and marked other than "natural". | ဥ                | LEWIS OWENS  |  |   |  |
| Maryland 21215-0036                 | permit. Pages 1 and 2 should<br>Department of Health and Men<br>Important: If Item 27 Is marke<br>eny Injury or other treumstic<br>once.   |                  | 19a. Informant's Name/Relationship (Type, Print) 19b. Ma CAROLYN V. OWENS / WIFE 41  | ling Address (Street and Number or Rural Route 09 SPRINGSLEIGH RD                            | Number, City or Town, State, RANDALLST(             | <sup>Zip Code)</sup> 21133<br>WN. MD                 |
|                                     | Healt<br>Healt<br>tem 2  |                  | 20a Method of Disposition 20b. Place of Dis  | position (Name of Date   | 20c. Location - City of                             |  |
| Baltimore,                          | Pages<br>ent of<br>nt: If I  |                  | 1 M Burial 2 □ Cremation 3 □ Removal from State MD VET 4 □ Donation 5 □ Other (Specify)  | ERANS CEM. 7/24/06<br>ON FOREST  | OWINGS M  | ILLS, MD   |
| a                                   | permit. Departm Importal eny Inju  | 1                | 21. Signature Juneral Service Licensee   | 22. Name and Address of Facility HOWELI  | L FUNERAL HO  | ME 21207   |
| <u> </u>                            | 8358   |                  | 1/ Muyur V 1) - Wally  | 4600 LIBERTY HEIGHT  | rs ave, balī  | 'IMORE, MD   |
| П                                   |  |                  | 23a. Fart1 Enter the disease, or complications that caused the doubt. Do not established, it heart ailure. List only one cause on each line. | nter the mode of dying, such as cardiac or respir  | atory arrest,                                       | Approximate<br>Interval Between<br>Onset and Death   |
| 2                                   | Pnysician  |                  | resulting in death)  | TER BACTEREM   | UA  | Oriset and Death                                     |
|                                     | /Medical<br>Examiner   |                  | Due to (or as a consequence of):   |  |   |  |
|                                     |  | er               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):                      |  |   |  |
| 1                                   | outed<br>ansit   | Examiner         | cause. Enter Underfying Cause (Disease or injury that initiated events c.  |  |   |  |
| ,09/                                | be executed<br>sician and<br>burial-transit  |                  | resulting in death) Last Due to (or as a consequence of):  |  |   |  |
|                                     | ā × ā  | dicai            | d  |  |   |  |
|                                     | certifi<br>ding I  | /Me              | IF FEMALE: 23c. If yes, outcome of pregnancy   |  | 23d. Date of d                                      | plivery  |
| Division of Vital Records, P.O. Box | death<br>d for u   | Physician/Med    | 1 Ves 2 No. 4 Pregnant at time of death 5  | ☐ Ectopic pregnancy ☐ Other (specify)  | Month   | Day Year   |
| Ö.                                  | by the   | hys              | 9 ☐ Unknown  |  |   |  |
| S,                                  | Attanding Physician: The law requires that the death certifical or death.  strobath.  ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the  | by F             | Part II. Other significant conditions contributing to death but not resulting in the<br>RENAL TRANSPLANT FOR (MRONIC                         |  | e. Did tobacco use contribute                       |  |
| ord                                 | requir   | eted             |  |  |   | Probably 4 □Unknown                                  |
| ည္သ                                 | has by   | Completed by     | PANCYTOPENÍA   | 24   | a. Was an 24b. Were a autopsy prior to death?       | autopsy findings available<br>completion of cause of |
| ē                                   | i <b>ician</b> : Th<br>certificate<br>rector, peg  | ပိ               | 25. Was case referred to medical   |  | Yes 2 No 1 ☐ Ye                                     |  |
| <u> </u>                            | ysicia<br>s cert<br>direct   | To Be            | examiner?  1  Yes 2 No  Hospital: 12 npatient 2 ER/Outpat  | 26. Place of Death Chec<br>ent 3 DOA Other: 4 Nursing Home 5                                 |   | ecify)   |
| 0                                   | ng Phys<br>ter this<br>neral di  | L:u              | 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time (Injury)                                     | of 28c. Injury at 28d. De  | scribe how injury occurred                          |  |
| Sio                                 | eath.<br>or: Af<br>the fu  | catle            | 2 Accident investigation   | M 1 Yes 2 No   |   |  |
| Σ                                   | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page   | Certification:   | 4 Homicide  4 Homicide  4 See Place of Injury - At home, farm, building, etc. (Specify)  | street, factory, office 28f. Loc<br>City   | cation (Street and Number or F<br>y or Town, State) | Rural Route Number,                                  |
|                                     | spital<br>ours a   |                  | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, de   | ath occurred at the time, date and place, and due  | to the cause(s) and manner                          | as stated.   |
|                                     | ne Ho  | Medical          | (Check only 2 Medical Examiner: On the basis of examination and/or one)  | investigation, in my opinion, death occurred at th   | e time, date and place, and du                      | e to the cause(s)                                    |
|                                     | To the To the Comp   | ×                | 29b. Signature and title of certifier  | 29c. License number  | 29d. Date signed (Mor                               |  |
| )                                   | CK   |                  |  | 254355   | JULY 1:   | 7 2006   |
|                                     | R  |                  | 30. Name and address of person who completed cause of death (Item 23a) (Typ NORTHWEST 代の3でTAL 5401 OLD                                       |  | المنادحين الم                                       | D 21133  |
|                                     | Sta  | te               | 31. Date filed (Month, Day, Year)  32. Restrar's Signature   | COURT WOND TOWND   | TOUS TO WIN P                                       | D C1133  |
|                                     | Registr  |                  | 31. Date filed (Month, Day, Year)  32. Resistrar's Signature  JUL 2 0 2006   | Specie   |   |  |
| _                                   |  |                  |  |  |   |  |

|                     |  |                | For<br>State<br>Registrar   | State of Ma   | -   | artment of H<br><i>rtificate of</i>                       |                      |  | giene2 () () ()<br>Reg. No.                        | 22756   |
|---------------------|--|----------------|---|---|---|---|----------------------|--|--|---|
| Ī                   | Physici<br>/Medic  |                | 1. Decedent's Name (First, Middle, Las<br>BEYERLY (   | ) WENS  |   |   |                      | 2. Date of De.<br>Month                    | 18 O   |   |
|                     | Examin   |                | 4a. Facility Name (If not institution, give GOOD SAMARITAN HOS  5. Social Security Number  6. So  | PITAL   | (In yrs. last birthday  | BALTIM  If Under 1 Year                                   | ORE  If Under 24 Hrs | 8. Date of Birt                            | 4c. County of Dea                                  | thplace (State or Foreign                                     |
| or .                | Funeral<br>Director  |                | 220-22-3508 Usual Residence of Decedent   |   | 79 Yrs.   | Months Days   | Hours Min            |  | y, Year) Co  | yland   |
|                     | e Marylan<br>Ba-f show   | Director       | Maryland N/A  |   | Baltimore   | 9   |                      |  |  | 10d. Inside City Limits                                       |
|                     | ath with the 23s or 2  |                | 700 West 40th Str   |   |   |   | 211                  |  | 10g. Citizen of What Co                            |   |
| 036                 | within 72 hours after death with the Maryland<br>ene.<br>Than "natural", or items 23a or 28a-f show<br>he Madical Examiner nated be notified at                    | by Funeral     | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced   | 12. Was Decedent E<br>Armed Forces?<br>1 Tyes 2 N<br>If Yes, Give<br>Year or Dates: |   | Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes 2X No | an, Mexican, Puer    | opecify Yes or No<br>to Rican, etc.)       | Black, Whit  |   |
| 2-0                 | "natur   | eted           | 15. Decedent's Ed<br>(Specify only highest gra  |   | (Give   | edent's Usual Occup<br>kind of work done                  | during most of wa    | orking                                     | 16b. Kind of Business                              | /Industry   |
| Maryland 21215-0036 |  | Completed      | Elementary/Secondary (0-12)   | College (1-4or 5-<br>2  | +)  | DO NOT use retire   |                      |  | Nursin   | q   |
| pu                  | d a b  | Be             | 17. Father's Name (First, Middle, Last)   | Unkno   |   |   | 18. Mother's Na      | me (First, Middle,                         | Maiden Surname)                                    | _   |
| Z                   | should be<br>ind Mental<br>s marked o<br>umatic eve  | 2              | 19a. Informant's Name/Relationship (  |   |   | ing Address (Street                                       | and Number or R      | ural Route Numbe                           | or, City or Town, State, .                         | known<br>Zin Code)  |
|                     | s 1 and 2 should<br>f Health and Mer<br>item 27 is marke<br>other traumatic  |                | Judith Campbell   | Friend  |   |   |                      |  | imore, Mary  |   |
| Baltimore,          | Page<br>nent o<br>ant: If<br>ury or  |                | 20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Nother (Specify 21. Signature of Fyneral Service Licen                                    | Mausoleum   | Lorraine  | matory or other pla<br>Park Cer                           | metery 7             | Date /21/06                                | 20c Location - City or<br>Woodlawn, M<br>Home, Inc | erul and  |
| Ä                   | permit. Departr Importa  |                | Aum B   | . Hens  | 2   | posi ratta  | s Road, I            | saltimore                                  | e, Maryland  |   |
|                     | Physician<br>/Medical<br>Examiner  |                | 23a. Part1. Entar the disease, or comshock, or leart failure. List only Immediate Cause (Final disease or condition resulting in death)                   | . Preu  | the death. Do not ene.  |   | ng, such as cardia   | c or respiratory ar                        | rest,  | Approximate<br>Interval Between<br>Onset and Death            |
|                     | <i>i</i>   | Examiner       | Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c.  | a consequence of):  |   |                      | 1-12-1-1                                   |  |   |
| 68760,1             | ificate be executed<br>g physician and<br>as the burial-transit  | dlcal          | Tesuling in dealing Last  | d.  | a consequence of):  | -   |                      |  |  |   |
| .O. Box             | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit | Physiclan/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown   | 23c. If yes, outcome of 1 ☐ Live birth 1 ☐ 4 ☐ Pregnant at 9 ☐ Unknown              | 2 ☐ Fetal déath 3 i   | Ectopic pregnanc<br>Other (specify)                       | у                    |  | 23d. Date of de<br>Month                           | ivery<br>Day Year   |
| ords, P.            | w requires that<br>been signed t<br>should be det  | þ              | Part II. Other significant conditions of  | entributing to death bu   | at not resulting in the o                                     | underlying cause giv                                      | ven in Part I.       | 23e. Did to                                | obacco use contribute to<br>Yes 2 No 3 □ Pr        | o the cause of death?   |
| Vital Records,      |  | Completed      |   |   |   |   |                      | 1 Tes                                      | prior to death?  2 No 1 Yes                        | utopsy findings available<br>completion of cause of<br>217 No |
| Vit                 | 8 v 5  | To Be          | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  | Hospital: Inpatier  | nt 2□ER/Outpatie  | nt 3 DOA Oth  | 200                  | ath <i>(Check only o</i><br>Home 5 ☐ Resid | ne)<br>lence 6 □Other (Spe                         | cifv)   |
| ion of              | After<br>fune  |                | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation   |   | y<br>Year) 28b. Time (<br>Injury                              | Wo  |                      |  | now injury occurred                                |   |
| Division            |  | Certification; | 3 Suicide 6 Could not be determined   | 28e. Place of Inju-<br>building, etc  | ury - At home, farm, si<br>:. (Specify)                       | reet, factory, office                                     |                      | 28f. Location (S<br>City or Tow            | Street and Number or Re<br>vn, State)              | ural Route Number,  |
|                     | To the Hospital within 24 hours a To the Funeral I completely filled   | ledical        | (Check only 2   Medical Exam  | ysician: To the best on<br>niner: On the basis of<br>and manner sta                 | examination and/or in   | nvestigation, in my o                                     | opinion, death occ   | urred at the time,                         | cause(s) and manner as<br>date and place, and due  | to the cause(s)   |
|                     | To T Com   | Σ              | 29b. Signature and title of dertified   | M.T   |   |   | - 000                | 0  | 29d. Date signed ( <i>Mont</i> 7 18 06             | h, Day, Year)   |
|                     | 5  |                | 30. Name and address of pers in who GOOD SAMARITAN H 31. Date filed (Month, Day, Year)  | OSPITAL S   | ath (Item 23a) (Type 560) 600 600 600 600 600 600 600 600 600 | RAYEN B   | LYD BA               | LTIMORE                                    | MD 212   | -39   |
| DH                  | Sta<br>Regist<br>MH 17 Rev 1/2   | rar            | JUL 2 0 20  |   | A A   | parties   |                      |  |  |   |

BEVERLY

|  |   |                      | 1 - For<br>State<br>Registrar   | State of M  | Marylan       | •                                |                |                              | eaith a<br>Death           | ind M     |                                      | Reg. No.2                    | 06                                     | 22                              | 757                   |
|--|---|----------------------|---|---|---------------|----------------------------------|----------------|------------------------------|----------------------------|-----------|--------------------------------------|------------------------------|--|---------------------------------|-----------------------|
|  | Physici   | an                   | Decedent's Name (First, Middle  |   |               |                                  |                |                              |                            |           | 2. Date of De<br>Month               | Day                          | Year                                   | 3. Time o                       | -                     |
|  | /Medi   | cal                  | Yvonne 4a. Facility Name (If not institution,   |   | thia          | -                                | 4h Cihi        |                              | tlow                       |           | 7                                    | 15                           | e E                                    | 4:4!                            | M                     |
| 1  | Examir  | ier                  |   | mane  | lanca:        | 1.0                              | 4b. City,      |                              | 11:MO                      |           |                                      | 4c. Coun                     | ny or Death                            |                                 |                       |
| 3  | Funeral   | F(#)                 |   |   | Age (In yrs.  | last birthday)                   |                | r 1 Year                     | If Under 2                 | 24 Hrs.   | 8. Date of Birt                      | th                           | 9. Birth                               | place (State                    | or Foreian            |
| 4.<br>   | Director  |                      | 212-34-1847   | 1 □ M <b>X X</b> F  | 67            | Yrs.                             | Months         | Days                         | Hours                      | Min.      | 08 2                                 | y, Year)                     | Cou                                    | in <i>try)</i> M [              |                       |
|  | pu ,  |                      | Usual Residence of Decedent   |   | 10- 0"        | -                                |                |                              |                            |           |                                      |                              |  |                                 |                       |
|  | ahov  | 7                    | MD NA   |   |               | y, Town or Lo<br>ltimo           |                |                              |                            |           |                                      |                              |  | 10d. Inside C                   | ity Limits<br>2 □ No  |
|  | 28a-1   | ecto                 | 10e. Street and Number  | <del></del>   | Da            | TCIMO                            |                | Code                         |                            |           |                                      | 10g. Citizen o               | 4 Mhat Car                             |                                 |                       |
|  | filed within 72 hours after death with the Maryland<br>Hygiene.<br>yther than "natural", or Itama 23a or 28a-f ahow<br>shit, the Madical Examinar must be codified at   | Funeral Director     |   | anal Basi   | 3             |                                  | 101. 21        |                              | 1215                       |           |                                      | -                            | S.A.                                   | -                               |                       |
|  | ma 23   | era                  | 3526 White Ch   | 12. Was Deceder   | nt Ever in U  | .S. 13. V                        | Was Dece       |                              |                            | gin? (Spe | ecify Yes or No<br>Rican, etc.)      |                              |  | ican Indian,                    |                       |
| 9  | or ita  | 교                    | 1 Never Married 2 Marri   | Armed Force  1 Tyes 2  If Yes, Give   |               |                                  |                |                              |                            | , Puerto  | Rican, etc.)                         | }                            | lack, White                            | , etc.                          |                       |
| 93   | rel,  | db                   | 3 Widowed 4 Divorced  | Year or Dates   | s:            |                                  | 1 🗆 Yes        | 21 <b>X</b> 40               | Specify:                   |           |                                      | Spec                         | Bl                                     | .ack                            |                       |
| 2  | natu  | Completed            | 15. Decedent<br>(Specify only highes  | s Education<br>! grade completed)   |               | 16a. Deced                       | kind of wo     | rk done d                    | urina most                 | of workii | ng                                   | 16b. Kind of                 | Business/li                            | ndustry                         |                       |
| 2  | within<br>sne.<br>than  | m                    | Elementary/Secondary (0-12)   | College (1-40   | or 5+)        | ///a. /                          | DO NOT I       | hier                         |                            |           |                                      | Giant                        | Food                                   | Stor                            | re                    |
| ე<br>ე   | filed<br>Hygid<br>Other   | C                    | 17. Father's Name (First, Middle, I   |   |               | 1                                |                | 11.1.0.1                     |                            | r's Name  | (First, Middle,                      |                              |  |                                 |                       |
| an   | ld be<br>ental<br>ked c   | To Be                | Louis D. Norr   | is  |               |                                  |                |                              | Velm                       | na C      | ornis                                | h                            | ,                                      |                                 |                       |
| Maryland 21215-0036  | shound Mind Mind Mind Mind Mind Mind Mind Mi  | -                    | 19a. Informant's Name/Relationsh  |   |               | 19b. Mailir                      | ng Address     | (Street a                    |                            |           | l Route Numbe                        |                              | n, State, Zi                           | ip Code)                        |                       |
| Ž  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Important: if item 27 is marked other than "natural, or itama 23a or 28a-f ahow any injury or other traumatic avent, the Madical Examiner must be rediffed at ance. |                      | Lynda Maddox-   | Daughter  |               | 3526                             | Whi            | te                           | Chape                      | el R      | load,                                | Baltin                       | ore,                                   | Md                              | 2121                  |
| ore  | of He of He filtern   |                      | 20a. Method of Disposition 1X Burial 2 ☐ Cremation  |   | 20b. F        | Place of Dispo<br>cemetery, cres | sition (Nai    | me of<br>other place         | 9)                         | D         | ate                                  | 20c. Location                | n - City or T                          | own, State                      |                       |
| Ě  | Pag<br>ment<br>ant: l   |                      | 4 ☐ Donation 5 ☐ Other (Sp  | ecity)  | Ki            | ng Me                            | mori           | al E                         | Park                       | 7/2       | 1/06                                 | Randa                        | illst                                  | own,                            | Μď                    |
| Baltimore,   | ermit<br>Depertuport<br>Deportuportuportuportuportuportuportuportu  |                      | 21. Sinuatur of Funeral Service L   | icensee   | 1.            | Ma                               | . Name ar      | F/H                          | s of Facility<br>West      | y         |                                      |                              |  |                                 |                       |
|  | 40240   |                      | 23a. Part1. Enter the disease, or   | nxill   | ar            | $\sim 43$                        | 00 W           | abas                         | sh Ar                      | /e,       | Balti                                |                              | Md                                     | 21215<br>Approxima              |                       |
|  | Physician<br>/Medical<br>Examiner   | Examiner             | shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Final Index in Cause (Disease or injury that initiated events | a   |               |                                  |                |                              |                            |           |                                      |                              |  | Interval Be<br>Onset and        |                       |
| O. Box 68760,  | The law requires that the death certificate be executed sie has leen signed by the ettending physicien and bege 2 should be detached for use as the buriel-transit  | Physician/Medical Ex | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   | c. Due to (or as a consequence of):  d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 |               |                                  |                |                              |                            |           |                                      |                              | 23d. Date of delivery<br>Month Day Yea |                                 |                       |
| P.O.   | s that t<br>ned by<br>a detac   | by Ph                | Part II. Other significant condition  | ns contributing to death  | but not res   | ulting in the u                  | nderlying o    | ause give                    | n in Part I.               |           | 23e. Did t                           | obacco use co                | ntribute to                            | the cause of                    | death?                |
| rds  | een sign  | ed b                 |   |   |               |                                  |                |                              |                            |           | 1 🗆 1                                | Yes 2□No                     | 3 ☐ Pro                                | bably 4 🕝                       | Unknown               |
| Division of Vital Records,   |   | Completed            |   |   |               |                                  |                |                              |                            |           | 24a. Was<br>autop<br>perfo<br>1 Tyes | osy<br>rmed?                 | prior to co<br>death?                  | opsy findings<br>ompletion of a | available<br>cause of |
| <u> </u>   | fcian: Th<br>certificate<br>rector, peg   | Be                   | 25. Was case referred to medical examiner?  | Hospital:   |               |                                  |                | Othe                         |                            |           | Check only o                         |                              |  |                                 |                       |
| ō  | tending Physician:<br>leath.<br>tor: After this certifica<br>the funeral director. I  | . To                 | 1 Yes 2 No  | 28a. Date of I  |               | ER/Outpatier<br>28b. Time of     |                | JA                           | 4 🔲 Nur                    |           | ne 5 ☐ Resid<br>28d. Describe I      |                              |  | ity)                            |                       |
| O  | ding<br>Afte<br>fune  | tion                 | 1 Natural 5 Pending 2 Accident Investig   | (Month, I   | Day Year)     | Injury                           | м .            | 28c. Injury<br>Work<br>1 □ Y | ?"<br>∕es 2 □ N            |           | LUG. D'OSCHILO                       | iow alluly occi              | u1160                                  |                                 |                       |
| Divisi   | or At<br>after of<br>Diraci<br>in by  | Certification:       | 3 Suicide 6 Could n<br>4 Homicide determi   | ot be 28e. Place of   | Injury - At h | ome, farm, str<br>y)             | eet, factor    |                              |                            |           | 28f. Location (3<br>City or Tox      | Street and Nur<br>vn, State) | nber or Rur                            | ral Route Nun                   | nber,                 |
|  | To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by   | edical (             | 29a Centifier 1 Certifyin (Check only one) 1 Medical E  | Physicien: To the he<br>examiner: On the basis<br>and manner  | of examina    | wledge, deall<br>ation and/or in | vestigation    | at the tim<br>, in my op     | a, date and<br>inion, deat | l place t | ed dua to the<br>ad at the time,     | date and place               | nanner as :<br>e, and due !            | clateu.<br>to the cause(        | s)                    |
|  | To the To the comp  | M                    | 29b. Signature and title of certifier   |   |               |                                  |                | c. License                   |                            |           |                                      | 29d. Date sign               |  |                                 | -                     |
|  | /   |                      | ) de  | L K Alavi   |               | MD                               |                | res                          | 8.30                       |           |                                      | 71115                        | 1.6                                    |                                 |                       |
|  | 5   |                      | 30. Name and address of person of Gelareh Kha   | jenoori A   | lavi,         | л 23а) (Туре,<br>М D             | Print)<br>5601 | Lo                           | ch Ro                      | avei      | Blv.                                 | d. Ba                        | 1 tim                                  | ore M                           | 1239                  |
| STATE OF THE PARTY | Sta<br>Regist   | ate<br>rar           | 31. Date filed (Month, Day, Year)   | 32. Regi  | strar's Signa | di-                              | book           | )                            |                            |           |                                      | ,                            |  |                                 |                       |

DHMH 17 Rev 1/2001

TVO Me parlow

|                                |  |                  | For<br>State<br>Registrar   | State of Maryland  |                               | rtment of H<br>tificate of L             |   |                                  | iene<br>og. No. 2006                 | 22758                           |
|--------------------------------|--|------------------|---|--|-------------------------------|--|---|----------------------------------|--------------------------------------|---------------------------------|
|                                | Dissolution  |                  | 1. Decedent's Name (First, Middle,  | Last)  |                               |  |   | 2. Date of Deat<br>Month         | h<br>Day Year                        | 3. Time of Death                |
|                                | Physici<br>/Medic  |                  | Robert  | William  | Pain                          | ter                                      |   | July                             | 16,200                               | 10:0 AM                         |
| }                              | Examin   |                  | 4an Facility Name (If not institution,  | give street and number)  | 1 1                           | 4b. City, Town, or                       | Location of Death                           |                                  | 4c. County of Dea                    | ath                             |
|                                |  |                  | BAltimoreluss   | VINCTON Wedvest  | enter                         | Glen Bur                                 |   |                                  | Anne Ar                              | unde1                           |
|                                | Funeral  |                  |   | 5. Sex 7. Age (In yrs. la<br>1 M 2 □ F 7.7                         | **                            | If Under 1 Year<br>Months Days           | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birth<br>(Month, Day, | Year) 9. Bi                          | rthplace (State or Foreign      |
|                                | Director   |                  | 226-30-8247   | 16 NU 2 LI F 77  | Yrs.                          |  |   | June 15                          | , 1929                               | VA                              |
|                                | and *  | 1                | Usual Residence of Decedenl  10a. State 10b. County   | 10c. City.   | Town or Loc                   | eation                                   |   |                                  |                                      | 10d. Inside City Limits         |
|                                | Aaryli<br>Peho   | 5                | MD Anne Ar  |  |                               |  |   |                                  |                                      | 1 □ Yes 2 No                    |
|                                | 28a-   | ect              | 10e. Streel and Number  | under Grei   | Burn:                         | 10f. Zip Code                            |   | 1,                               | 0g. Citizen of What C                | ioustry?                        |
|                                | a or   | Funeral Director |   | Annonolio Plad   |                               | 21061                                    |   |                                  |                                      | contry :                        |
|                                | eath<br>ne 23  | era              | 11. Marital Status  | Annapolis Blvd.  12. Was Decedent Ever in U.S                      |                               | 1  | spanic Origin? /Spa                         |                                  | U.S.A.                               | erican Indian                   |
|                                | Item<br>Item   | Ę                | 1 ☐ Never Married 2 Marrie  | Armed Forces?  |                               |  | spanic Origin? (Spe<br>n, Mexican, Puerto I | Rican, etc.)                     | Black, Wh                            |                                 |
| 99                             | urs al   | by I             | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:                                     | 1                             | ☐Yes 21 No                               | Specify:                                    |                                  | Specify:                             | White                           |
| ŏ                              | within 72 hours after death with the Manyland<br>ene.<br>Than "neturel", or lieme 28a or 28a-i ehow<br>he Madigal Exeminer must be motified at   |                  | 15. Decedent's  | Education  | 16a. Deced                    | ent's Usual Occupa                       | ation                                       |                                  | 16b. Kind of Business                | s/Industry                      |
| 215                            | nin 7  | ple              | (Specify only highest<br>Elementary/Secondary (0-12)  | grade completed)  College (1-4or 5+)                               | (Give F                       | kind of work done o<br>O NOT use retired | furing most of working)                     | ng                               |                                      |                                 |
| 7                              | d with   | Completed        | 8   | Conege (11401 34)  | Chemi                         | cal Opera                                | itor  |                                  | Chemical (                           | Company                         |
| Þ                              | oth oth  | ВеС              | 17. Father's Name (First, Middle, Li  | ist)   |                               |  | 18. Mother's Name                           | (First, Middle, M                | Maiden Surname)                      |                                 |
| <u>a</u>                       | Aents<br>Aents<br>rked<br>ttc •  | 70 6             | Clarence W. Pa  | inter  |                               |  | Ellen Le                                    | e Buckn                          | er                                   |                                 |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mentle Hygiene. Deportment of Heelih and Mentle Hygiene.  Bronstant: If them 27 is marked other than "naturely, or theme 23a or 28a-1 show any injury or other treumatic event, the Mudical Examinar must be notified at Once. |                  | 19a. Informant's Name/Relationshi   | p (Type, Print)  | 19b. Mailing                  | g Address (Street a                      | and Number or Rura                          | l Route Number,                  | City or Town, State,                 | Zip Code) 21061                 |
| ≥ .                            | s 1 and 2<br>of Heelth a<br>ltem 27 ls<br>other tree   | 7,               | Mrs. Shelby Pai   |  |                               |  | e & Annap                                   | olis Bl                          | vd. Glen 1                           | Burnie, MD                      |
| ore                            | of Her   |                  | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3   |  | ace of Dispos<br>metery, crem | sition (Name of<br>atory or other place  | July  | 20.                              | 20c. Location - City o               | r Town, State                   |
| Ĕ                              | Pag<br>nent<br>ant: I<br>ury o   |                  | 4 □Donation 5 □Other (Spe   |  | ıden Pa                       | ark Cem.                                 | 200   |                                  | Baltimore,                           | MD                              |
| a                              | Depenti<br>Depenti<br>Importi<br>any in  |                  | 21. Signalure of Funeral Service Li   | censee   | 22.                           | Name and Addres                          | s of Facility Sin                           |                                  | Funeral Ho                           |                                 |
| _                              | 8979   |                  | Mark fr.  | Vaneura Moi  | 3571                          | Second A                                 |   |                                  | rnie, MD 2                           |                                 |
|                                |  |                  | 23a. Part1. Enter the disease, or c<br>shock, or heart failure. List or                                     | omplications that caused the death.<br>nly one cause on each line. | Do not ente                   | or the mode of dying                     | g, such as cardiac o                        | r respiratory arre               | est,                                 | Approximate<br>Interval Between |
|                                | Pnysician :  | 0.4              | Immediate Cause (Final disease or condition   | 171  | 401-76                        | CICALE.                                  | wis   |                                  |                                      | Onset and Death                 |
|                                | /Medical   |                  | resulting in death)   | Due to (or as a conseque   | 1                             |  |   |                                  |                                      |                                 |
|                                | Examiner   |                  | Conscitate let equitions  | FAT  | AL                            | BRAD4                                    | ARRYTI                                      | wist                             |                                      |                                 |
|                                | <b>₽</b> €   | iner             | Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conseque   | ence of):                     |  |   |                                  |                                      |                                 |
|                                | ecute<br>ind<br>trans  | Examin           | Cause (Disease or injury that initiated events resulting in death) Last                                     | c  |                               |  |   |                                  |                                      |                                 |
| Ö,                             | e exc<br>ien a<br>urial-   | <u> </u>         | resulting in obatin cast  | Due to (or as a conseque   | ence of):                     |  |   |                                  |                                      |                                 |
| 8760,                          | that the death certificate be executed<br>ed by the attending physicien and<br>detached for use as the burial-transit  | ledical          |   | d  |                               |  |   |                                  |                                      |                                 |
| 9                              | leath certifica<br>attending ph<br>ifor use as ti  | Me               | IF FEMALE:  | 00.16  |                               |  |   |                                  |                                      |                                 |
| Box                            | ath cuttend  | lan/             | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of pregnan<br>1☐Live birth 2☐Fetal o          | death 3□                      | Ectopic pregnancy                        |   |                                  | 23d. Date of de<br>Month             | Day Year                        |
|                                | the a  | Physician/M      | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4□Pregnant at time of dea<br>9□Unknown                             | ath 5∐                        | Other (specify)                          |   |                                  |                                      | .,                              |
| P.O.                           | that the de<br>ned by the a<br>detached  |                  |   | s contributing to death but not resul                              | ting in the un                | derlying cause give                      | on in Part I                                | 23e Did lot                      | pacco use contribute                 | to the cause of death?          |
| of Vital Records,              | ires tha<br>signed<br>d be de  | by               |   |  | and an are on                 | donying oddso give                       | min and a                                   |                                  |                                      | Probably # Unknown              |
| O                              | law requires<br>as been sign<br>2 should be  | Completed        |   |  |                               |  |   |                                  |                                      |                                 |
| 3ec                            | e law<br>has l   | Jd L             |   |  |                               |  |   | 24a. Was au<br>autops<br>perform | y prior to                           | completion of cause of          |
| <u>=</u>                       | t. The   |                  |   |  |                               |  |   |                                  | 2€No 1 □ Ye                          |                                 |
| Ξ                              | Physician: This certificerral director, p  | Be               | 25. Was case referred to medical examiner?  | Hospital:  |                               | Othe                                     | 26. Place of Death                          |                                  |                                      |                                 |
| of                             | Phys<br>this<br>al dii   | P.               | 1 Yes 2 No  | 1 mpatient 2 E   | R/Outpalient<br>28b. Time of  | 3 DOA                                    | 4 Nursing Hon                               |                                  | nce 6 Other (Spenier injury occurred | ecify)                          |
|                                | ding<br>After<br>fune  | 5                | 1 ☐Natural 5 ☐ Pending  | (Month, Day Year)  | Injury                        | 28c. injury<br>Work                      | (?<br>Yes 2 □No                             | .ou. Describe no                 | w injury occurred                    |                                 |
| S                              | Attending r death. actor: After by the fune  | Ca               | 3 ☐ Suicide 6 ☐ Could no  | ot be Gran Diago of Johnson At hos                                 | ne farm stre                  |  |   | Rf Location (St                  | reet and Number or F                 | Jural Route Number              |
| Division                       | after death<br>after death<br>Director:  | Certification:   | 4 Homicide determin   | building, etc. (Specify)   | )                             | ot, lactory, office                      |   | City or Town                     |                                      | arar riodio rember,             |
|                                | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Attencompletely filled in by the funer   |                  | 29a. Certifier 1 Certifying   | Physician: To the best of my know                                  | rledge, death                 | occurred at the tim                      | ne, date and place a                        | and due to the ca                | ause(s) and manner a                 | s stated.                       |
|                                | Ho<br>24 h<br>Fur<br>etely   | edical           | (Check only 2 Medical E   | xaminer: On the basis of examination and manner stated.            | on and/or inv                 | estigation, in my op                     | pinion, death occurre                       | ed at the time, da               | ate and place, and du                | e to the cause(s)               |
|                                | To the within 2 To the complet   | Me               | 29b. Signature and title of certifier   | 2  |                               | 29c. License                             | number                                      | 25                               | 9d. Date signed (Mon                 | th, Day, Year)                  |
|                                | 8  |                  | 1   | 0, 6   |                               | 1  | 05570                                       | 2                                | ToPa 16                              | 2506                            |
|                                | 1  |                  | 30. Name and address of person w  | no completed cause of death (Item :                                | 23a) (Type. F                 | Print) m = = =                           | Do-1  | )                                | und in                               | , 00-0                          |
|                                | 10   |                  |   | 1 10512516-3   |                               | ucrica                                   | bernane<br>Z                                | 1,200                            | 5200 3L                              | , 2006                          |
| 17                             | Sta  | ite              | 31. Date filed (Month) Pay, Year)   |  | ITB TO                        |  |   |                                  |                                      |                                 |
|                                | Registr  | rar              | 902 200   | filling D  | Signal                        | WES .                                    |   |                                  |                                      |                                 |

|   |                     | 1 - For State Registrar  | ate of Maryla   | •                  | rtment of Hotificate of L                 |                                |   | ne (                | 06                    | 22759   |
|---|---------------------|--|---|--------------------|---|--------------------------------|---|---------------------|-----------------------|---|
|   |                     | Decedent's Name (First, Middle, Last)  |   |                    |   |                                | 2. Date of Death                                      |                     |                       | 3. Time of Death                                |
| Physici   |                     | Frank E. Potepan   |   |                    |   |                                | July 13   | , 200               | Year<br>6             | 1:20 AM M                                       |
| /Medio<br>Examin  |                     | 4a. Facility Name (If not institution, give street   | and number)   |                    | 4b. City, Town, or                        | Location of Death              |   |                     | ty of Death           |   |
| LAGITIII  | Ŭ.                  | Charlestown Retire   | ement Cent  | er                 | Catons                                    | ville                          |   | Ва                  | ltimo                 | re  |
| Funeral   |                     | Social Security Number     6. Sex  |   | . last birthday)   | If Under 1 Year<br>Months Days            | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, )                    | 'ear)               | 9. Birth              | place (State or Foreign<br>intry)               |
| Director  |                     | 210-12-3838 <sup>¹™™</sup>   | 82  | Yrs.               |   |                                | June 7,   | 1924                | Yugo                  | sĺavia  |
| pu 🔭  |                     | Usual Residence of Decedent  10a. State 10b. County  | 10c (   | ity, Town or Loc   | cation                                    |                                |   |                     |                       | 10d. Inside City Limits                         |
| sho   | 5                   |  |   |                    |   |                                |   |                     |                       | 1 ☐ Yes 2 ☐ No                                  |
| the N   | ect                 | MD Baltimore  10e. Street and Number   |   | Catonsv            | 10f. Zip Code                             |                                | 100   | . Citizen of        | What Cor              |   |
| with  | ā                   | 707 Maiden Choice L  | ane 8T02  |                    |   | 1228                           |   |                     | SA                    | ,   |
| within 72 hours after death with the Maryland ene. ene. https://withan.haturail.or/itams 23s or 28s-f show ha Madical Esaminer most te modified at                | by Funeral Director |  | /as Decedent Ever in  | U.S. 13. V         | Vas Decedent of His<br>Yes, specify Cubar |                                | ecify Yes or No-                                      |                     |                       | ican Indian,                                    |
| riter d   | 표                   | 1 Never Married 2 Married 1  | rmed Forces?<br>☐ Yes 2 No  |                    |   |                                | Rican, etc.)  |                     | ack, White            |   |
| urs a   | þ                   | 3 ☐ Widowed 4 ☐ Divorced   | Yes, Give<br>ear or Dates:  | 1                  | ☐ Yes 21X No                              | Specify:                       |   | Spec                | ity: wh:              | ite   |
| 72 hours af   | Completed           | 15. Decedent's Educatio<br>(Specify only highest grade con   | n<br>nole ted l   |                    | lent's Usual Occupa                       |                                | ing 16  | 6b. Kind of         | Business/I            | ndustry   |
| Mithin<br>ne.   | du                  |  | College (1-4or 5+)  | life. L            | OO NOT use retired,                       | )                              |   |                     |                       |   |
| filed withi<br>Hygiene.<br>other than   | S                   | 12   | 4   | forem              | an  | 40.14.4.4.1                    |   | machi               |                       | nop   |
| d be file   | Be                  | 17. Father's Name (First, Middle, Last)  |   |                    |   |                                | e (First, Middle, Ma                                  | uden Suma           | ітө)                  |   |
| 2 should be for and Mental lis marked or  | ဥ                   | Frank Potepan  | a '- Al   | 405 14:35          | Add (C                                    |                                | nia Rotz  | Oite on Tour        | - Cto to 7            | in Code)  |
| d 2 sh<br>th and<br>th and<br>treum   |                     | 19a. Informant's Name/Relationship (Type, F<br>Constance Potepan/s   |   |                    | g Address <i>(Street</i> a<br>Maiden Ch   |                                |   |                     |                       | , MD 21228                                      |
| E E E   |                     | 20a. Method of Disposition   |   | Place of Dispos    |   |                                | _   | c. Location         |                       |   |
| Pages 1 ar<br>nent of Hea<br>int: If itsm<br>ury or oths  |                     | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo<br>4 ☒ Donation 5 ☐ Other (Specify)                                      | ŀ   | cemetery, crem     | natory or other place                     |                                |   |                     | ,                     | Simily Grand                                    |
| permit. Pages 1<br>Department of H<br>Important: If its<br>any injury or ot<br>page.  |                     | 21. Signature of Fineral Service Licensee Ronal d S Wa   | Directo   |                    | Name and Addres<br>ate Anato<br>ltimore,  |                                |   | Baltim              | nore                  | Street  |
|   |                     | 23a. Part. Enter the disease, or complication  | ns that caused the de   |                    |   |                                |   | t,                  |                       | Approximate<br>Interval Between                 |
| Pnysician   |                     | shock or heart failure. List only one ca<br>Immediate Cause (Final   | use on each line.   | uluk               | come                                      |                                |   |                     |                       | Onset and Death                                 |
| /Medical  |                     | disease or condition resulting in death)   | Due to (or as a cons  | ,                  |   |                                |   |                     |                       |   |
| Examiner  |                     |  |   |                    |   |                                |   |                     |                       |   |
| _   | Je                  | Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a nonsi   | squance of).       |   |                                |   |                     | - 14                  |   |
| cuted<br>nd<br>ransi  | Examine             | that initiated eventsc.  |   |                    |   |                                |   |                     |                       |   |
| e exe   |                     | resulting in death) Last   | Due to (or as a cons  | equence of):       |   |                                |   |                     |                       |   |
| death certificate be executed eathending physicien end of for use as the burial-transit   | dical               | d  |   |                    |   |                                |   |                     | +                     |   |
| aling p   |                     | IF FEMALE:   | fues euteems of pres  | Dana.              |   |                                |   |                     |                       |   |
| es that the death certific<br>igned by the attending p<br>be detached for use as  | Iclan/Me            | 230. Was decedent pregnant   | f yes, outcome of preg<br>I □Live birth = 2 □ Fe<br>I □ Pregnant at time of | ital death 3       | Ectopic pregnancy Other (specify)         |                                |   |                     | ate of deli-<br>nonth | Day Year  |
| he de ched  | ysic                |  | Unknown   | dealii 5           | Other (specify)                           |                                |   |                     |                       |   |
| The law requires that the tee bas been signed by the lage 2 should be detached.   | Physi               | Part II. Other significant conditions contribu   | iting to death but not r  | esulting in the ur | nderlying cause give                      | en in Part I.                  | 23e. Did toba   | cco use co          | ntribute to           | the cause of death?                             |
| sign d be   | d by                | empure   | ma, 1   | arku               | want of                                   | iscare                         | 1 ☐ Yes   | 2 🗆 No              | 3 □ Pro               | bably 4 □Unknown                                |
| vican necolus, iiclan: The law requires t certificate has been signe rector, page 2 should be o   | Completed           |  | 1 outu  | tre                |   |                                | 24a. Was an   | 245                 | Were au               | tonsy findings available                        |
| has<br>has  | E G                 |  | pu  | -7                 |   |                                | autopsy   | 902                 | death?                | topsy findings available completion of cause of |
|   |                     | OF IMparators and an addition  |   |                    |   |                                |   | No                  | 1 ☐ Yes               | 2 No  |
| sicls<br>certi  | o Be                | 25. Was case referred to medical examiner?  1 Yes 2 No Hosp  | ital:<br>1 ☐ Inpatient 2  | □ EB/Outpotion     | it 3 DOA Othe                             | ar _                           | th <i>(Check</i> on <i>ly</i> one)<br>ome 5 ☐ Residen |                     | that /Case            | 164   |
| Trithis raid  | H                   |  | Ba. Date of Injury  | 28b. Time of       | I 3 DOA                                   | WEST WUISHING FI               | 28d. Describe hov                                     |                     |                       | ary)  |
| l or Attending Phy<br>after death.<br>Director: After this<br>I in by the funeral d   | 후                   | 1 Natural 5 Pending 2 Accident investigation   | (Month, Day Year)   | Injury             |   | <br Yes 2 □No                  |   |                     |                       |   |
| Atten<br>deal<br>r deal<br>pctory   | #Ca                 | 3 Suicide 6 Could not be   | 8e. Place of Injury - At  | home, farm, str    | eet, factory, office                      |                                | 28f. Location (Stre                                   |                     | nber or Ru            | ral Route Number.                               |
| el or   | Certification:      | 4 Homicide   | building, etc. (Spe   | uiy)               |   |                                | City or Town,   | Jiai <del>o</del> ) |                       |   |
| To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director. | edical              | 29a. Certifier Contrying Physicia (Check only and)   |   |                    |   |                                |   |                     |                       |   |
| o the<br>ithin (<br>o the<br>omple  | Med                 | 29b. Signature and title of certifier  | and manner stated.  |                    | 29c. License                              | e number                       | 29  | d. Date sign        | ned (Monti            | n, Day, Year)                                   |
| F≯F8  |                     | 1  | am s  | 60-                | Dec                                       | 0200                           | 40  | 7/1                 | 10                    | 106   |
|   |                     | 30. Name and address of person who compl   |   | em 23a) (Type,     | Print) M A                                | el on                          | Chan.   | 0/                  | - I                   | Catonial Catonial                               |
|   |                     | 31. Date filed (Month, Day, Year)  | 666   | nature             | 10  | VVIV                           | with the  |                     | 7                     | 140   |
| Regist  | ate<br>rar          | JUL 2 0 2006   | 2. Registrar's Sig  | is Apa             | W.  |                                |   |                     |                       | 1 72/22   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|                            |  |                  | State of Maryland / Departm  |   | al Hygiene                             | 2000                                      | 00760  |
|----------------------------|--|------------------|--|---|--|---|--|
|                            |  |                  | Registrar  | eate of Death   | Reg. No                                | .4000                                     | 44/60  |
|                            | Physici  | an               | 1. Decedent's Name (First, Middle, Last)   |   | ate of Death<br>Ionth Da               | Year                                      | 3. Time of Death                                   |
|                            | /Medic   | al               | Teggy Kobinson  As Facility Name (If not institution, give street and number)  As (If not institution, give street and number)   | City, Town, or Location of Death  | 19 13                                  | County of Death                           | 11 / "   |
|                            | Examin   | er               | Musishand General Alkaital B   | altimuse 177  | 4                                      | N A                                       |  |
|                            | Funeral  |                  |  | nder 1 Year   If Under 24 Hrs.   8 Da   | ate of Birth                           | 9. Birtho                                 | olace (State or Foreign                            |
|                            | Director   |                  | 214-50-7245 10 M 20 F 61 Yrs. Mon  |   | Month, Day, Year                       | Cour                                      | MD   |
| _                          | D.   |                  | Usual Residence of Decedent  |   |  |   |  |
|                            | arylan<br>show   | 'n               | 01.  |   |  |   | 0d. Inside City Limits 1 ☐ Yes 2 🖪 No              |
|                            | or death with the Maryla<br>tems 23s or 28s-1 sho<br>set must be collified at  | Funeral Director | MD Baltimore Baltimore   | . Zip Code  | 10a Ci                                 | tizen of What Cour                        |  |
|                            | with   | 늄                |  |   |  | 1   | iti y r  |
|                            | leath  | era              |  | 21217<br>ecedent of Hispanic Origin? (Specify Y<br>specify Cuban, Mexican, Puerto Rican | res or No-                             | 14. Race - Americ                         | can Indian,  |
| 7 6                        | after dea<br>or items  | F                | 1 ■ Never Married 2 Married 1 Tyes 2 Married   |   | , etc.)                                | Black, White,                             | etc.   |
| 3                          | rei', c  | 1 by             | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:   | es 2 <b>/</b> No <i>Specify</i> :   |  | Specify: Blo                              | ck   |
| 75 P                       | within 72 hours after death with the Maryland<br>ene.<br>then "natural", or items 23s or 28s-1 show<br>he Medical Esamir or must be motified at  | Completed        | (Specify only highest grade completed) (Give kind o  | Usual Occupation  f work done during most of working                                    | 16b. h                                 | (ind of Business/In                       | dustry   |
| b1/<br>121                 | vithin<br>hen '  | m<br>jd          | Elementary/Secondary (0-12) College (1-4or 5+)   | OT use retired)   | 0.                                     | - 1                                       | RPCR+  |
| 32                         |  |                  | 17 Father's Name (First, Middle, Last)   | ASSOCIATE  18. Mother's Name (Firs  | B. Middle, Maide                       |   | RPERT  |
| Land                       | ould be filed<br>Mental Hygi<br>arked other<br>atic event, I   | o Be             | George Robinson Sp.  | Florence  | Payne                                  |   |  |
| 275                        | 2 should be filed<br>and Mental Hygi<br>is marked other<br>reumatic syent,   | ဥ                |  | Iress (Street and Number or Rural Rou   |  |   | Code)  |
| 85₹                        | 교육등급   |                  | Renee Phillips 722 N.  | Carrollton Ave, &   | 3attmos                                | E MD a                                    | דובו   |
| Je, sie,                   | permil. Pages 1 and<br>Department of Healt<br>Important: If Item 2<br>any Injury or other<br>once.   |                  | 20a. Method of Disposition 20b. Place of Disposition   | (Name of Date   | 20c. L                                 | ocation - City or To                      | own, State   |
| imo                        | Pages<br>nent of<br>ant: if it   |                  | 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)   | 7/19/2  | 006 Pal                                | +more,                                    | MD   |
| Baltimore                  | permit. Pag<br>Department<br>Important: I<br>sny injury o  |                  |  | e and Address of Facility   |  |   |  |
|                            | 20 E # 9   |                  | rough C. Greene 5151   | 13ato Nati Pike   | Baltin                                 | dee, MD                                   | 21229  |
|                            |  |                  | 23a. Part1. Enter the tisease, or complications that caused the death. Do not enter the shock, or heart fathere. List only one cause on each line.   | mode of dying, such as cardiac or resp  | piratory arrest,                       |   | Approximate<br>Interval Between<br>Onset and Death |
|                            | Physician  |                  | Immediate Cause (Final disease or condition a Hemarking in The Cause of Cau | roke  |  |   | Oliset and Death                                   |
|                            | /Medical<br>Examiner   |                  | resulting in death)  Due to (or as a consequence of);  | alcolle will and  | ht ilam                                | inland                                    |  |
|                            |  | 7                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   | STI ENESWITH NUM  | u Hern                                 | pregio                                    |  |
| Pers                       | ned insit  | Examine          | Cause (Disease or injury   | 1/0550/ Diseas  | e_                                     |   |  |
| Pro                        | ate be executed thysician and the burial-transit   | Exa              | that initiated events resulting in death) Last   C  C  Due to (or as a consequence of):  | 16170   |  |   |  |
| 8760,                      | ate be<br>hysicia<br>the bur   | <u>e</u>         | d  |   |  |   |  |
| 9                          | tifica<br>ng ph<br>as th   | ledi             | 15 FF. A. I. F.  |   |  |   |  |
| Вох                        | th cer<br>tendir<br>ir use   | an/h             | IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectop   | nic pregnancy   |  | 23d. Date of delive                       |  |
| . E                        | e dea<br>the at  | Physician/Medic  | in the past 12 months?  1 Yes 2 Voo 9 Unknown  1 Unknown   | r (specify)   |  | Month                                     | Day Year   |
| P.O.                       | hat the d by I   | Phy              | 9  | ing cause given in Part I   | 23e Did tobacco                        | use contribute to the                     | ne cause of death?                                 |
|                            | signe<br>d be c  | i by             | Hypertension Deables Melitis,  | Coronary  | 1 ☐ Yes 2                              |   | . /  |
| Š                          | y requ   | Completed        | Appell Disease Consider 1/00   | 54 6  | 24a. Was an                            |   | any findings available                             |
| Rec                        | has<br>ge 2  | m                | rikgery Distase, Corgestiae reg  | - 1   | autopsy<br>performed?                  | death?                                    | psy findings available impletion of cause of       |
| a                          | n: Th  | ပိ               | 25. Was case referred to medical   |   | ☐ Yes 2 2 No                           | 1 ☐ Yes                                   | 2 No   |
| <u> </u>                   | s cert   | 0 0              | examiner? Hospital:  | 26. Place of Death Che  DOA Other: 4 Nursing Home                                       |  | 6 ∏Other (Specif                          | iv)  |
| o o                        | Phy<br>er this   | Ë                | 27. Manner of Death 28a. Date of Injury 28b. Time of   |   | Describe how inju                      |   | ,,   |
| Ö                          | ath.<br>r: Ate   | atio             | 1 ☑Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation M   | 1 Yes 2 No  |  |   |  |
| Division of Vital Records, | er de<br>recto   | ertification;    | 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)   |   | ocation (Street a                      | nd Number or Rura                         | il Route Number,                                   |
|                            | itato<br>irs aft<br>rai Di<br>led in   | O                |  |   |  |   |  |
|                            | Hosp<br>4 hou<br>Funa<br>fely fil  | edicai           | 29a. Certifier  (Check only   Certifying Physician: To the best of my knowledge, death occu 2  | rred at the time, date and place, and di<br>ation, in my opinion, death occurred at     | ue to the cause(s<br>the time, date an | s) and manner as s<br>d place, and due to | tated.<br>o the cause(s)                           |
|                            | To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atlending p completely filled in by the funeral director. page 2 should be detached for use as: | Med              | one) and manner stated.  29b, Signature and title of certifier   | 29c. License number   | 29d. Da                                | ate signed (Month,                        | Day, Year)   |
|                            | F 3 F 8  |                  | My by Krololugan, MD   | 89 555  | 7                                      | 15/00                                     |  |
|                            |  |                  | 30, Name and address of person who completed gause of death (Item 23a) (Type, Print)   | 6/ 00 /   |  | 1.0104                                    | 1 10   |
|                            | 7  |                  | Mohammed Koddugaru, M.D.   | 40 Maryland   | Grem                                   | eral H                                    | uspital  |
|                            | Sta  | ate              | 31. Date filed (Month, Day, Year) 32. Fedstrar's Signature   |   |  |   | 7  |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [6] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1ards on 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner CEDARDALE TIMOR KOAD If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreig **Funeral** Days 1XM 2 F Months Hours 216--830 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Show ritsms 23a or 28a-f shov free must be notified at 1 XYes 2 No Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 (X) ves 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ANo Specify is marked other then "natural", o aumatic svent, the Medical Exar 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (MASTERS DEGREE) TEACHER 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be and Mental RICHARDS ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a :: if itsm 27 is r or other tra 3404 CEDAR NAILE ORETTA RICHARDSON WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location City or Town, State 1 Burial 2 Cremation 3 □Removal from State important: if any injury o once. CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) METRO 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Do not enter the mode of dying, such as carding or respiratory arrest Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit To the Hospital or Attending Physicisn: The law requires thet the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as ed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ should I 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page this certificate 1 Yes 2 No 1 Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 2 No Certification: To 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Injury 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0032548 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Street, OLVIN MAD North

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State Registrar

31. Date filed (Mont

10

32. Registrar's Signature

|  | 1              | For<br>State<br>Registrar  | State                                   | of Mary                                   | land / Dep<br><i>Ce</i>                 |                                      | nt of Hei<br>te of De               |                               |   | giene 2                     | 006  | 2276   |
|--|----------------|--|---|---|---|--------------------------------------|-------------------------------------|-------------------------------|---|-----------------------------|--|--|
| Physician  | _              | 1. Decedent's Name (First, Middle, Milton Reizenst   |   |   |   |                                      |                                     |                               | 2. Date of Dea<br>Month<br>JUL                              | Day                         | Year<br>2006                                   | 3. Time of Death 5 10:15A                            |
| /Medical   |                | 4a. Facility Name (If not institution, g   | give street and n                       |   | enter                                   | 4b. City                             | , Town, or Lo                       | fcation of Death              | h   |                             | nty of Death                                   | <del></del>  |
| Funeral<br>Director  |                |  | .Sex<br>1 [X] M 2 ☐ F                   |   | yrs. last birthday                      | If Unde<br>Months                    |                                     | f Under 24 Hrs.<br>Hours Min. | 8. Date of Birt<br>(Month, Da<br>July 10                    | y, Year)                    | Cou  | place (State or Foreig<br>intry)<br>cyland           |
|  |                | Usual Residence of Decedent  10a. State 10b. County  MD  10e. Street and Number  |   |   | c. City, Town or L<br>Baltimor          | e                                    | p Code                              |                               |   | 10g. Citizen                |  | 10d. Inside City Limit: 1  Yes 2 No                  |
| Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel; or items 23a or 28e-f ehow enty inury or other traumatic event, the Medical Experiment must be notified at once.  To Be Commissed by Filners Director  | Dy runeral Di  | 6300 Blenheim R  11. Marital Status  1 Never Married 2 Marrier 3 W Widowed 4 Divorced  | 12. Was De<br>Armed F                   | : 2 X No<br>Bive                          | in U.S. 13.                             | Was Dece<br>If Yes, spo              | ecify Cuban,                        |                               | pecify Yes or No<br>to Rican, etc.)                         | - 14. F                     | SA<br>Race - Amer<br>Black, White<br>city: Wh: | , etc.   |
| lygiene. her then "nature nt, tre Medical E.   | Completed      | 15. Decedent's<br>(Specify only highest<br>Elementary/Secondary (0-12)<br>1 2  | Education<br>grade completed<br>College |   | (Giv.                                   | edent's Usi<br>e kind of w<br>DO NOT |                                     | ing most of wo                |   | 16b. Kind of                | ical<br>ore C                                  | bureau   |
| arked oth  | ō              | 17. Father's Name (First, Middle, La<br>Milton Reizenst  | ein                                     |   |   |                                      | F                                   | Rose Ho                       | ne (First, Middle,<br>11ander                               |                             |  |  |
| attraum  |                | 19a. Informant's Name/Relationship Jeffrey Rhoades   |   |   | 1                                       |                                      |                                     |                               | ural Route Numbe<br>Baltimor                                | -                           |  | ip Code)   |
| int: If Item<br>iry or oth   | 9              | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spe  |   | 1   | Ob. Place of Disp<br>cemetery, cre      | osition (Na<br>ematory or            | me of<br>other place)               |                               | Date  | 20c. Locatio                | n - City or 1                                  | Fown, State  |
| Imports<br>eny Inju  |                | 21. Signature of Euneral Project Li<br>RODA I d. S<br>MMM  | censee<br>Wade                          | Direct                                    |   |                                      | nd Address<br>Anaton<br>ore, M      |                               | d 655 W.  | Balti                       | more   | Street   |
| sician and the burial-transit the burial-transit the burial-transit the burial-transit and the burial transit and the burial transition to the burial transition transition to the burial transition to the burial transition transition to the burial transition tra | Ĭ              | 23a. Part1. Enter the disease or conditions, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. LU  Due to                           | NG AB o (or as a co                       | death. Do not end SCESS insequence of): | nter the mo                          | de of dying,                        | such as cardia                | c or respiratory ai   | rrest,                      |  | Approximate Interval Between Onset and Death 9 MONTH |
| by the ettending physitached for use as the  |                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  |   | birth 2 🗆<br>gnant at time                | Fetal death 3                           | □Ectopic p<br>□ Other (s             |                                     |                               |   | 1                           | Date of deli                                   | very<br>Day Year                                     |
|  |                | Part II. Other significant condition   | s contributing to                       | death but no                              | ot resulting in the                     | underlying                           | cause given                         | in Part I.                    |   | obacco use c<br>Yes 2XINo   |  | the cause of death?                                  |
| cete has   | e Completed    | 25. Was case referred to medical   |   |   |   |                                      |                                     |                               | 1 ☐ Yes   | rmed?<br>2000 No            | prior to c death?                              | topsy findings availat<br>ompletion of cause o       |
|  | 0              | examiner?  1 Yes 2 XNo  27. Manner of Death  1 X Natural 5 Pending  2 Accident investiga   | 28a. Dat<br>(Mc                         | Inpatient<br>te of Injury<br>onth, Day Ye | 2 ☐ ER/Outpation 28b. Time Injury       |                                      | OA Other:<br>28c. Injury a<br>Work? | 4 Nursing H                   | ath (Check only of<br>dome 5 Residence 1<br>28d. Describe I | dence 6 🗆                   |  | rify)  |
| el Directo<br>ed in by th  | Certification: | 3 Suicide 6 Could no<br>4 Homicide determin  | 286. Pla                                | ce of Injury -<br>Iding, etc. (S          | At home, farm, s<br>pecify)             | treet, facto                         | ry, office                          |                               | 28f. Location (3<br>City or Tox                             | Street and Nu<br>vn. State) | mber or Ru                                     | ral Route Number,                                    |
|  | Medical        |  | xaminer: On the                         |   | mination and/or                         |                                      |                                     |                               | e, and due to the<br>urred at the time,                     |                             |  |  |
| o the  | Σ              | 29b. Signature and rille of continer   | /                                       |   |   | 29                                   | c. License n                        | umber                         |   | 29d. Date sig               | ned (Month                                     | Day, Year)   |

armer

Physician

**Funeral** 

Director

filed within 72 hours after death with the Maryland th and Mental Hygiene. ?? is marked othar than "natural", or Itema 23a or 28e-f ehov treumatic avent, the Medical Examinat must be notified at Funeral Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sewing Machine Operator 9th permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Important: if Itam 27 is marked oth any liquy or other treumatic avent 900. 17. Father's Name (First, Middle, Last) Be Benjamin Stahlin 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Moreland Park 20a. Method of Disposition 1

■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee nn Immediate Cause (Final disease or condition resulting in death) Brady Cardia Physician /Medical Due to (or as a consequence of): Examiner Stenosis Hortic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine physicien and the burial-transit Hospitel or Attanding Physicien: The law requires thet the death certificate be executed Heart Failure Due to (or as a consequence of) Box 68760 ymphoma Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.0. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ٥ Completed 25. Was case referred to medical examiner? Be ျှ 1 ☐ Yes 2 ☑ No Inpatient 2 ER/Outpatient 3 DOA this within 24 hours efter death.

To the Funerel Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical 흡 29c. License number 29b. Signature and title of certifi-Res 0000 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 2006 Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 5:29 PM Scharmer Gertrude 06 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore oseda Franklin Square Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 26, 1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 2**X**F 219-03-0818 86 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Essex MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21221 USA 8620 Kelso Drive 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Specify: White 16b. Kind of Business/Industry Clothing 18. Mother's Name (First, Middle, Maiden Sumame) Gertrude Lindner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn R. Coleman Sr. /son 8813 Avondale Road Baltimore MD 21234 20c. Location - City or Town, State 7/21/06 Baltimore MD 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes ₽ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) \*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dev. Year) Dr. Innocent Wonya Tambi, 9000 Franklin Square Hospital Drive, Baltimore, MD 21237

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene George Thomas Shriver 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ 0104 hrs Medical Examine George July 18, 2006 Thomas Shriver Sr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 6 Sex Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Months Days Hours Min Director 1 X M 2 F 219-40-4834 29,1943 62 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 1 Yes 2 X No or 28a-f show notified at once. MD Anne Arundel Glen Burnie after death with the Maryland Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 21060 l Southfield Road U.S.A. or items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 8lack must be Armed Forces' White, etc. Never Married 2 Married 2X No Yes 1 Yes 2 X No specify: White f Yes, Give Year imore, MD 21215-0036
Pages I and 2 should be fited within 72 hours after near of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural". ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) or other traumatic event, the Medical Truck Driver Westinghouse 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be George William Shriver Ruth Judy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. George Thomas Shriver Jr. 7757 Monaghan Road Glen Burnie, MD 21060 20a Method of Disposition 20b Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) July 21, 1 XBurial 2 Cremation 3 Removal from State Important: Glen Haven Mem. Park Donation 5 Other Specify. 2006 <u>Glen Burnie MD</u> 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061 NW1357 anh Paneure Pal 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial -Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown signed by t be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed peen

Division of Vital Records, P.O.

certificate has To the Hospital or Attending Physician: After this thin 24 hours a

the f

Be

Certification:

2

|                                   |                                   |                          |                             | 24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No |
|-----------------------------------|-----------------------------------|--------------------------|-----------------------------|--|
| . Was case referred to medical    |                                   |                          | 26.Place of Death (Check    | only one)  |
| examiner?  1 ✓ Yes 2 No           | Hospital: 1 / Inpatient 2         | ER/Outpatient 3          | DOA Other Nursi             | ng Home 5 Residence 6 Other:   |
| 7. Manner of Death                | 28a. Date of Injury               | 28b. Time of Injury      | 28c. Injury at Work?        | 28d. Describe how injury occurred  |
| Natural 5 Pending                 | Jul 1, 2006                       | 1117 hrs                 | 1 Yes 2 V No                | motorcyclist in motor vehicle accident   |
| Accident Investigation            |                                   |                          |                             |  |
| Suicide 6 Could no                | t be 28e. Place of Injury - At he | ome, farm, street, facto | ry, office building, etc.   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                         |
| Homicide determine                | ed (Specify) Major Road           | d / Highway              |                             | Ritchie Hwy and Farrington Road, Glen Burnie,  |
| 9a. Certifier 1 Certifying Physic | rian: To the hest of my knowled   | ge death occurred at t   | he time, date and place, an | due to the cause(s) and manner as started  |

O.C.M.E.

July 19, 2006

📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. 29c. License number 29d Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD.

31. Date filed (Month, Day, Year) Registrar's Signature State 0 2006 Registrar

Lo

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** July 8. 2006 12:13 PM Olin Sims /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 301 McMechen Street If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov 5, 1912 9. Birthplace (State or Foreign Country)
S. Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 93 Director 251-22-5663 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or itams 23a or 28a-f show It e Madical Examinar must be notified at 1√2 Yes 2 □ No Completed by Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA 301 McMechen Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: black Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) janitor nursing homes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other traumatic event Isaac Sims Minnie Suber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Cook/grandaughter 803 Kevin Road Baltimore, MD 21229 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Director 21 Signature of Euneral Service Licenses State Anatomy Board 655 W. Baltimore Street 'n 7000 Baltimore, MD 21201 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory mest Approximate Interval Between Onset and Death art 1. Enter the disease ack, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine death certificate be executed the attending physician and ned for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying care given Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 90 3 ☐ Probably 4 ☐ Linknown 1 🗌 Yes 2 🗆 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 🗌 Yes 217 No 1 🗌 Inpatient 2 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident I or Attend after death Diractor: filled in by the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a To the Funerat D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 D12729 782 EMMY S 30. Name and address of person who completed cause of death (Item 23a) (Type, Printing a robon 8W1. RAND 21216 32/Registrar's Signature 31. Date filed (Month, Day, Year) State 2 9 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** Juanita Smith 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore If Under 24 Hrs. 8. [ 1(11) TAI Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M ¾□ F Director So. Carolina 243-12-4408 Apr 20, 1929 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28a-f show other traumatic event, the Medical Examiner rust be notified at 1X Yes 2 □ No Baltimore Director N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21244 USA 3612 Rockdale Street \*natural', or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ Black 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other fraumatic event, Ite Me. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Day Care Provider 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Dozier Wilson Doziei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3612 Rockdale Street Baltimore, Maryland 21244 Debra Bowens 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 👿 Burial 2 □ Cremation 3 □ Removal from State 07/22/06 Brooklyn Park, Md. 4 ☐ Donation 5 ☐ Other (Specify) Çedar Hill Cemetery & Mausoleum 21. Signaure Funeral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Approximate Interval Between Onset and Death to hot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) therosclevitic andre Vertelle Physician years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit the attending physician and thed for use as the burial-tran Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Tyes 2 No 4 Pregnant at time of death 5 Other (specify) detached Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. quetrue 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 - No 2 No 1 🗌 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. s after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \) within 24 hours a To the Funeral L To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

900

who completed cause of death (Item 23a) (Type, Print)

Scruger WW)
006 Registrar's Sign

29c. License number

Carpy Avenue

|  |                  | For   | State of Ma                               | ryland /                            | -              |  |                                   | Mental Hy                       | giene                         | 06 00765   | -1 |
|--|------------------|---|---|-------------------------------------|----------------|--|-----------------------------------|---------------------------------|-------------------------------|--|----|
|  |                  | 1 - State<br>Registrar  |   |                                     | Cer            | tificate of L  | Death                             |                                 | Reg. No U                     | Ub 22/6/   | 1  |
| Physic   | ian              | 1. Decedent's Name (First, Middle, L.   |   | 7-10                                |                |  |                                   | 2. Date of Dea                  | Day                           | 3. Time of Death   |    |
| /Medi  | cal              | DRUSICLA  | SPENC                                     |                                     | T+             | 45 City Town   | A continue of Death               | 107-1                           | 3-20                          | 106 9:45 PM  |    |
| Exami  | ner              | 4a. Facility Name (If not institution, gi   | ve street and number)<br>[LE COMMON]      | 16 Fu                               | sting          | 4b. City, Town, or   | altime                            |                                 | 4c. County                    | Limbur County  | ,  |
| Euparal  |                  | Deficate de l'all   |   | (In yrs. last b                     | irthday)       | If Under 1 Year  | If Under 24 Hrs.                  | 8. Date of Birt                 | h Day                         | 9. Birthplace (State or Foreign                          | 2  |
| Funeral<br>Director  |                  | 219-16-0724   | 1□M 2 <b>x</b> □F                         | 81                                  | Yrs.           | Months Days  | Hours Min.                        | (Month, Da                      |                               | Maryland   |    |
| pu ,   |                  | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City, To                       |                |  |                                   | <u> </u>                        |                               |  |    |
| lanyla<br>shov   | 7                |   | Arundel                                   | Toc. City, 10                       | WIT OF EOC     |  | sadena                            |                                 |                               | 10d. Inside City Limits 1 ★ Yes 2 No                     |    |
| the N  | ect              | Maryland Anne  10e. Street and Number   | Alunder                                   |                                     |                | 10f. Zip Code  | Sauciia                           |                                 | 10g. Citizen of V             |  | _  |
| with<br>Ba or  | Funeral Director | 7840 Levy Court - Apt 6   | 319                                       |                                     |                | Total Exp Godg   | 21122                             |                                 | Tog. Chizon or t              | U.S.A.   |    |
| death<br>ms 2:   | era              | 11. Marital Status  | 12. Was Decedent E                        | ver in U.S.                         | 13. V          | Vas Decedent of Hi<br>Yes, specify Cuba                          |                                   | pecify Yes or No                | - 14. Rac                     | e - American Indian,                                     |    |
| after after or Ite   |                  | 1 Never Married 2 Married   | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give | 0                                   | i .            | Yes, specify Cuba  | n, Mexican, Puert  Specify:       | o Rican, etc.)                  |                               | ck, White, etc.  |    |
| Sours<br>Sours<br>Fire 1   | d by             | 3 ₩ Widowed 4 □ Divorced  | Year or Dates:                            |                                     |                |  | Specily.                          |                                 | Specify                       | y: Black   |    |
| n 72 h   | lete             | 15. Decedent's 8<br>(Specify only highest g   |   | 16                                  | (Give I        | ent's Usual Occupa<br>kind of work done of<br>OO NOT use retired | during most of wor                | rking                           | 16b. Kind of Bu               | usiness/Industry   |    |
| withir ene.  | Completed        | Elementary/Secondary (0-12)   | College (1-4or 5-                         | -)                                  | me. L          |  | Technician                        |                                 | De                            | pt. of the Army  |    |
| be filed within 72 hours after death with the Maryland lat Hygiene. Id Hygiene. Id other than "natural", or Items 23a or 28a-1 show event, the Madical Evarrinar must be rotified at   | Be Co            | 17. Father's Name (First, Middle, Las   | it)                                       |                                     |                |  |                                   | ne (First, Middle,              | Maiden Suman                  | ne)  |    |
| Id yidild A IX IS-0000<br>2 should be filed within 72 hours after death with the Marylan<br>and Mental Hygiene.<br>Is marked other than "natural", or Items 23a or 28a-f show<br>aumatic event, the Medical Examinar must be notified at   | To B             | Emory /   | A. Johnson                                |                                     |                |  |                                   | M                               | illie Rustin                  |  |    |
| III. III. Pages 1 and 2 should be filed within 72 hours atter death with the Maryla artment of Health and Mental Hygiene.  ortant: If item 27 is marked other than "natural", or Items 23a or 28a-1 show injury or other traumatic event, the Medical Evantinal must be notified at injury or other traumatic event.   |                  | 19a. Informant's Name/Relationship  |   | 19                                  |                | g Address (Street a  |                                   |                                 | -                             | State, Zip Code)   |    |
| of Health<br>Fitem 27  |                  | Delores Spencer Daug  | hter                                      | 20h Place                           | -              | 62 Solley Roa<br>sition (Name of                                 | ad Glen Buri                      | nie, Marylan<br>Date            |                               | City on Town Charts                                      |    |
| Pages 1<br>Tent of H<br>ont: If ite  |                  | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3   |   | cemet                               | ery, crem      | atory or other plac  | 1                                 |                                 |                               | - City or Town, State                                    |    |
| DallIIIIOr permit. Pages Department of Important: If it any injury or o  | ļ                | ' 4 ☐ Donation 5 ☐ Other (Spec  |   | Ba                                  |                | National Ce Name and Addres                                      | -                                 | 07/18/06                        | Ba                            | altimore, Md.  |    |
| Dall<br>permit.<br>Departr<br>Importa<br>any inju  |                  | FILMONO   | 1 Il ho                                   | OKOL                                | 0              | Estep Br   | others Fune                       | ral Service                     | P. A                          |  |    |
| THE REAL PROPERTY.   |                  | 23a. Part1. Enter the disease, or conshock, or her failure. List only                                       | mplications that caused                   | the death. Do                       | o not ente     | r the mode of dyin   | taw Place B<br>g, such as cardiad | or respiratory ar               | rest,                         | Approximate<br>Interval Between                          | _  |
| Physician  |                  | Immediate Cause (Final disease or condition   | y one cause on each line                  | chine                               | 14             | part Fa  | illino                            |                                 |                               | Onset and Death  |    |
| /Medical   |                  | resulting in death)   | a. Due to ( s a                           | consequence                         | e of):         | 1 1  | D                                 | /                               | 9900 1                        | 27.50  |    |
| Examiner   | L                | Sequentially list conditions,   | b. Chror                                  | 210                                 | Op.            | structi  | ive Pu                            | mona                            | ry Disc                       | 9950   |    |
| l ed   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a                           | consequenc                          | e of):<br>// / | emen!  | 40                                |                                 |                               |  |    |
| sxecul<br>and  | xan              | that initiated events<br>resulting in death) Last   | c. Holde                                  | consequence                         | ساي<br>e of):  | eriev!   | 14                                |                                 |                               |  | _  |
| icate be executed physician and sthe burial-transit  | dical E          |   | d   |                                     |                |  |                                   |                                 |                               |  |    |
|  | ledi             |   |   |                                     |                |  |                                   |                                 |                               |  |    |
| th cert  | an/N             | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of 1□Live birth      |                                     | th 3 □         | Ectopic pregnancy  |                                   |                                 |                               | te of delivery   |    |
| IS, P.O. BOX of the state of th | hysiclan/Me      | in the past 12 months?  | 4☐ Pregnant at t<br>9☐ Unknown            |                                     |                | Other (specify)  |                                   |                                 | Мо                            | onth Day Year  |    |
| d by t   | Phy              | 9 Unknown  Part II. Other significant conditions  | contributing to death bu                  | t not resulting                     | in the un      | idochrina causo anu  | on in Part I                      | 23a Did to                      | hacco usa cont                | tribute to the cause of death?                           |    |
| ords, F.C. requires that the een signed by th nould be detache   | 1 by             | Turn one organization   | continuously to about ba                  | r not roodining                     | , iii tiito di | outlying cause give  | on an anti-                       | 1 🗆 1                           |                               | 3 Probably 4 □Unknown                                    |    |
|  | eted             |   |   |                                     |                |  |                                   | 24a, Was                        | 20 24h )                      | Were autopsy findings available                          | _  |
| VICAL MEC. sician: The law certificate has b lirector, page 2 st   | Comple           |   |   |                                     |                |  |                                   | autop                           | rmed?                         | prior to completion of cause of death?                   |    |
| VICE<br>ician: T<br>certificat<br>ector, pa  | C                | 25. Was case referred to medical  |   |                                     |                |  | 26 Place of Dea                   | 1 ☐ Yes                         |                               | 1 ☐ Yes 2 ☐ No   |    |
| OT VICA Physician: this certific ral director,   | 0 8              | examiner?<br>1 ☐ Yes 2 ☐ No   | Hospital:                                 | nt 2 ER/C                           | Outpatient     | t 3□ DOA Othe  | 00                                | lome 5 Resid                    |                               | er (Specify)   |    |
| on or vita<br>ding Physician:<br>h.<br>After this certific<br>funeral director,  | ı.i.             | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day        | Year) 28b                           | Time of        | 28c. Injun<br>Worl   | / at                              |                                 | now injury occur              |  |    |
| SION<br>tending<br>death.<br>tor: Afte<br>the fune   | atic             | 2 ☐ Accident investigate  | on  |                                     |                |  | Yes 2 □ No                        |                                 |                               |  |    |
| or Attender deal   | ertification:    | 3 Suicide 6 Could not determine   |   | ry - At home,<br>. <i>(Specify)</i> | farm, stre     | eet, factory, office   |                                   | 28f. Location (S<br>City or Tox | Street and Numb<br>vn, State) | per or Rural Route Number,                               |    |
| pital purs a pral E  | al Ce            | 29a. Certifier 1 Certifying I   | Physician: To the best o                  | f my knowled                        | ne death       | accurred at the ti-  | ne date and size-                 | and due to the                  | C2U00/a) a=d ==               | appear as stated   | _  |
| DIVISION  To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After I completely filled in by the funeral   | edica            | (Check only 2 Medical Ex  | aminer: On the basis of<br>and manner sta | examination a<br>led.               | and/or inv     | estigation, in my o  | pinion, death occu                | irred at the time,              | date and place,               | and due to the cause(s)                                  |    |
| To th<br>within<br>To th<br>compl  | ₩                | 29b Signature and title of certifier  | 1M 1                                      | MAN                                 | mo             | 29c. License   | e number                          |                                 | 29d. Date signer              | d (Month, Day, Year)                                     |    |
|  |                  | Jougnilles  | Exgled,                                   | MD,                                 | 11151          | Da   | 05641                             | 4                               | 7-14                          | F-06   |    |
| 2  |                  | 30. Name and woress of person wh  | o completed cause of de                   | ath (Item 23a                       | (Type, I       | Print)   | n                                 | 20110                           | Rolls                         | d (Month, Day, Year)<br>F-OG<br>MOR <sub>(</sub> MD 2122 | 20 |
|  |                  | Jocelyn 1   | 1- E1-Sa                                  | Signature                           | 16             | Fustiv   | ig HVE                            | me,                             | MITIN                         | 2016/01/12/11  | -0 |
| St<br>Regis  | tate<br>trar     | 31. Date filed (Month, Day, Year)  JUL 2 0  | 2006 32. Headstra                         | Kar Signature                       | 1              | Cartes   |                                   |                                 |                               |  |    |
| 3.0  |                  | 704 70  | 1000                                      | ~                                   | 200            | Action British   |                                   |                                 |                               |  |    |

06-05072 Marguies Smith

# Please Type or Print in Black Indelible Ink

| larquies Smith   |                   | For State  | yland / Departm<br><i>Certific</i>        | ent of Health<br>ate of Death                 | and Mental Hyg                                      | giene<br>Reg. N                           | vo. 200                            | 6 2276  |
|--|-------------------|--|---|---|---|---|------------------------------------|---|
| Physician<br>Medical Examine   | 1                 | gistrar Decedent's Name (First, Middle, Last)  Marawes   | Snith                                     |   |   | Date of Death Month Da July 15, 2006      | y Year                             | 3. Time of Death<br>0804 hrs                    |
| Medical Examina  |                   | Facility Name (if not institution, give street and Sinai Hosptial  |   | 4b. City, Tow                                 | n, or Location of Death                             |   | 4c. County of Death                |   |
| Funeral  | 5                 | Social Security Number 6. Sex  | 7. Age (In yrs. last bir                  | Months  | Year If Under 24Hrs.  Days Hours Min                | 8. Date of Birth(N                        | /M/DD/YYYY) 9 Birtl<br>Foreign     |   |
| Director   | U                 | 18-35 - 9384 1 M 2 sual Residence of Decedent  | F I                                       | Yrs.  |   | May 22                                    | , 1772                             | 10d. Inside City Limits                         |
| nd<br>ihow any   |                   | Da. State 10b. County NA   | 10c. City, Town                           | or Location Ba                                | Himere  |   |                                    | 1 Yes 2 No                                      |
| more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f show rother traumatic event, the Medical Examiner must be notified at once. | Director          | De. Street and Number  3.311 St. Ambase  | Are.                                      | 10f. Zip Co                                   | 21215   | 10g.                                      | Citizen of What Coun               | try?  |
| ath with the items 23a   | – 1–              | Never Married 2 Married Arme   | Decedent Ever in U.S.                     |   | of Hispanic Origin? (Specuban, Mexican, Puerto R    |   | 14. Race - Americ<br>White, et     | an Indian, Black,                               |
| safter de<br>ural", or i   | ⋧┝                | 1 Yes, Gliver and In Yes, Gliver | Year                                      |   | No specify cupation (Give kind of wo                | rk done 16                                | Specify. Specify.                  | ndustry   |
| )36<br>thin 72 hours af<br>ne.<br>than "natural<br>ledical Examin  | Completed         |  | ge (1-4 or 5+)                            |   | g life. DO NOT use retire                           | d)  | NA                                 |   |
| 215-0036 be filed within 7 ntal Hygiene, rked other than ent, the Medica   |                   | 7. Father's Name (First, Middle, Last)  Tames Thomas   |   |   | 18.Mother's Name (                                  | First, Middle, Maid                       | den Surname)                       |   |
| ID 21215-( should be filed and Mental Hyg 77 is marked oth   | To Be             | 9a. Informant's Name/Relationship (Type, Print   | of Cather 15                              | 9b. Mailing Address                           | (Street and Number or Ru                            | iral Route Numbe                          | City or Town, State                | Zip Code) 2/2/5                                 |
| imore, MD 2121. Pages I and 2 should be filment of Health and Mental I are if item 27 is marked or other traumatic event.  | _                 | Oa. Memod of Disposition   |   | of Disposition (Name<br>atory or other place) |   | Date 2                                    | Oc. Location - City or             | Town, State  Ne Maryland                        |
|  |                   | Donation 5 Other Specify:  Signature of Tun ral Service Licensee   | M+. 2                                     | 22. Name and A                                | ddress of F cilit                                   | 206 C                                     | and Home                           | P.A.  |
| Balti<br>Permit<br>Departi<br>Import<br>injury o   | -                 | 3a. Part I. Ent. r the isease, or complications to   | nat caused the death. Do r                | 3512 Fr                                       | denck Are.<br>dying, such as cardic or              | Patimer<br>respiratory arrest,            | Maryand<br>slock, or heart         | Approximate Interval<br>Between Onset and       |
| /Medical   |                   |  | thadone intoxic                           | ation   |   |   |                                    | Death   |
|  |                   | Sequentially list conditions, b  | as a consequence of):                     |   |   |   |                                    |   |
|  | Ë                 | cause. Enter Underlying Cause  | as a consequence of):                     |   |   | -   |                                    |   |
|  |                   | d.  X UNPENDED AMEND   | ped item#23a,PI                           | I,27,28a-f,p                                  | erME,g857,7/28,                                     | /06 TT                                    |                                    |   |
| 8760, ificate be ag physici  | n/Med             | 3b. Was decedent pregnant in the   | yes, outcome of pregnanc<br>ive birth     | y<br>2 Fetal death                            | 3 Ectopic pregnar                                   | псу                                       | 23d Date of delivery Month         | y<br>Day Year                                   |
| that the death certificat<br>red by the attending ph<br>detached for use as the  | Physician/Medical | , C y O D N O C Halanana C C   | Pregnant at time of death<br>Unknown      | 5 Other (Special                              | (y)   |   |                                    |   |
| P.O. Es that the gned by the detached  | ğ                 | Part II. Other significant conditions contribu   | ting to death but not result              | ing in the underlying o                       | ause given in Part I                                | 23e. Did toba                             | acco use contribute to             | the cause of death?  pably 4  Unknown           |
| ords, P.O. In requires that the as been signed by the should be detached.  | Completed         |  |   |   |   | 24a. Was an<br>autopsy<br>perform         | prior to                           | topsy findings available completion of cause of |
| tal Records riam: The law requi certificate has been   |                   | 25. Was case referred to medical   |   | 26  | 6.Place of Death (Check of                          | 1 <b>✓</b> Yes 2                          |                                    | es 2 No   |
| Vital  <br>ysician:<br>his certifi<br>director.  | o Be              | examiner?  1 ✓ Yes 2 No  | Inpatient 2 🗸 ERA                         | Outpatient 3 DC                               |   |   | esidence 6 Othe                    | r   |
| rn of Vi<br>nding Physi<br>h.: After this<br>e funeral dir   | -1                | 27, Manner of Death 28a.   | (Month, Day, Year)                        | o. Time of Injury 28                          |   | 28d Describe how                          | w injury occurred                  |   |
| Division of Vital Records, P.O. Ital or Attending Physician: The law requires that it strete death.  **All Directors: After this certificate has been signed by led in by the funeral director, page 2 should be detact  | Certification:    | 2 Accident Investigation 3 Suicide 6 X Could not be  | Place of Injury - At home ecify) found at | , farm, street, factory,                      | office building, etc                                | 28f. Location (Stror Town, Star Baltimore | eet and Number or Rute) 3311 Saint | ral Route Number, City<br>Ambrose               |
| Hospi<br>24 hou<br>Funer<br>rely fil   |                   | 4   Homicide   29a Certifier (Check only one)   2 Medical Examiner: On the   | ne hest of my knowledge.                  | death occurred at the                         | time, date and place, and opinion, death occurred a | due to the cause(                         | s) and manner as sta               | ted<br>ne cause(s)                              |
| To the within To the Comple  | Medical           |  | nner stated                               |   | License number                                      |   | 29d Date signed (Mo                |   |
| O  |                   | 30. Name and address of person who complete  | d cause of death (Item 23a                | a)  | O.C.M.E.  |   | July 16, 2006                      |   |
| - Per  | 119               | Patricia Aronica-Pollak MD. A  | ssistant Medical Exa                      | aminer 111 Pe                                 | nn Street, Baltimor                                 | e, MD 21201                               |                                    |   |
| S<br>Regis   | tate<br>trar      | 31. Date filed (Month, Day, Year) JUL 2 0 2006   | 32 Registrar's Signature                  | ROBINE  |   |   |                                    |   |

06-04911 John Thompson

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

| 2   | 0 | 0 | 6  | 2    | 2   | 7   | 6 |
|-----|---|---|----|------|-----|-----|---|
| 100 | 0 | 1 | 10 | 6.40 | See | - 1 | V |

|   |                | 1- For State<br>Registrar                                 |                      |                               | Cer                                  | tificate       | of Deat                     | 7          |             |          |                   | Reg. No.   | 4                 | UU             | b                      | 6610                 |
|---|----------------|---|----------------------|-------------------------------|--------------------------------------|----------------|-----------------------------|------------|-------------|----------|-------------------|------------|-------------------|----------------|------------------------|----------------------|
| Physicia  |                | Decedent's Name (First,                                   | Middle,Las           | ast) 2. Date of Death         |                                      |                |                             |            |             |          |                   | V          |                   | 3. Time of     |                        |                      |
| edical Exami  |                | Johnni  | 9                    |                               |                                      | Tho            | mpson                       |            |             |          | Month<br>July 10, | 2006       | Year              |                | 1839                   | hrs                  |
|   |                | 4a. Facility Name (if not ins                             | titution, giv        | e street and nu               | imber)                               |                | 4b. City, 7                 | own, or L  | ocation of  | Death    |                   | 40         | c. County o       | f Death        |                        |                      |
| لمميد   |                | 1426 Federal Str  | et                   |                               |                                      |                | Baltin                      | ore        |             |          |                   |            | N                 | IA             |                        |                      |
| Funeral   |                | 5. Social Security Number                                 | 6. S                 | ex                            | 7. Age (In yrs. la                   | ast birthday)  | If Und                      | r 1 Year   | If Under    | 24Hrs.   | 8. Date of E      | Birth(MM   | /DD/YYYY)         |                |                        | ite or               |
| Director  |                | 217-86-1570   | 152                  | M 2 F                         | 3                                    | ο .            | Month                       | Days       | Hours       | Min.     | 04-2              | 6-67       | 7                 | Foreigr<br>Cou | n<br>Intry) <b>M</b> d |                      |
| •   | H              | Usual Residence of Deced                                  |                      | 10. 2                         |                                      | 9              |                             |            |             | 1        | 010               |            |                   |                |                        |                      |
| È   | H              | 10a. State 10b. C   |                      |                               | 10c. City,                           | Town or Lo     | cation                      |            |             |          |                   |            |                   |                | 10d. Inside            | e City Limits        |
| - A   |                | Md. Ha  | rford                |                               |                                      | Edge           | boows                       |            |             |          |                   |            |                   |                | 1 Yes                  | 2 X No               |
| yland<br>P-f sh   | į              | 10e. Street and Number                                    |                      |                               |                                      |                | 10f. Zip                    | Code       |             |          |                   | 10a Cit    | izen of Wh        | at Coun        |                        |                      |
| Mar<br>r 28a  | Director       | 810 Sleepy  | u_11_                | T. Ct                         |                                      |                | 101. 21                     |            | 040         |          |                   | rog. Cit   | USA               | at Coun        | uy:                    |                      |
| ith the Maryland<br>23a or 28a-f show any<br>n tifred at once.  |                |   | поттс                |                               |                                      |                |                             |            |             |          |                   |            |                   |                |                        |                      |
| h wit   | Funeral        | 11. Marital Status  1 XNever Married 2                    | Married              | A                             | cedent Ever in U.<br>orces?          |                | Was Decede<br>If Yes, speci |            |             |          |                   | No-        | 14. Race<br>White |                | can Indian,            | Black,               |
| deat<br>or ite  | 5              |   |                      | 1 X Yes                       | 2 No                                 |                |                             |            |             |          | . ,               |            |                   |                | 1                      |                      |
| after<br>aft",<br>iner  | ģ              | 3 Widowed 4   |                      | If Yas, Give Yea<br>or Dates: |                                      | 1              | Yes 2                       |            |             |          |                   |            | Specify:          |                | ack                    |                      |
| 10urs   | - pa           | 15. Decedent's Education                                  | •                    |                               |                                      |                | dent's Usual<br>most of wo  |            |             |          |                   | 16b.       | Kind of Bus       | siness/Ir      | ndustry                |                      |
| 136<br>Thin 72 hounge.<br>Than "natedical Exa   | Completed      | Elementary/Secondary                                      | 0-12)                | College (                     | 1-4 or 5+)                           |                | e Impr                      | _          |             |          | ,                 | Ca         | rney              | Wal            | lpape                  | r& Paint             |
| orthir<br>ra th   | m d            | 12th grade  |                      |                               |                                      | 110111         | - 111122                    |            |             |          |                   |            |                   |                |                        |                      |
| 5-00<br>led with  |                | 17. Father's Name (First, I                               | fiddle, Last         | )                             | Clark                                |                |                             | 1          |             |          | First, Middle     | , Maider   |                   | klas           |                        |                      |
| 21215-0036  Muld be filed within 72 hours after that Hygiene, marked other than "natural", cevent, the Medical Examiner.  | Be             | John  |                      |                               | CIGLA                                |                |                             |            | Bets        | -        |                   |            |                   |                |                        |                      |
| D 21<br>hould<br>nd Me<br>is ma   | To             | 19a. Informant's Name/Re                                  | . ,                  | ,, ,                          |                                      |                | ling Address                |            |             |          |                   |            |                   |                | Zip Code)<br>21040     |                      |
| , MD 21215-0036 and 2 should be lifed within 72 hours after death with the Maryland tealth and Mende Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-1 she traumatic event, the Medical Examiner must be neitlifed at once  |                | Betsy Daklas  |                      | Mot                           | ther                                 |                | 0 Slee                      |            |             |          |                   |            |                   |                |                        |                      |
| nore, MD 2 gges 1 and 2 should to f Health and N t: If item 27 is n other traumatic   |                | 20a. Method of Disposition 1 Burial 2 X Cre               |                      | Romoval fr                    |                                      |                | position (Na<br>other place |            | etery,      |          | Date              | 20c.       | Location -        | City or        | Town, State            | е                    |
| Baltimore,<br>permit. Pages I a<br>Department of He<br>Important: If ite  |                | 4 Donation 5 O  |                      |                               | on state                             |                | ount (                      |            |             | 7-19     | 9-06              | Ba         | altimo            | ore,           | Md.                    |                      |
| Baltimo<br>permit. Page<br>Department of<br>Important:<br>injury or otd   |                | 21. Signature of Funeral S                                |                      |                               |                                      |                | 2. Name and                 |            | of Facility |          | Ralti             | more       | e, Md             |                | 21202                  | ,                    |
| Ban Perm Dep Dep Iniju  |                | 1 lad   | -0 1                 | 1) an                         | (2)                                  |                | March                       | F.H        | . Eas       | st       | 110               | E.         | Nort              | h Av           |                        | ·                    |
| Physician   |                | 23a. Part I. Enter the disea                              |                      | plications that o             |                                      | . Do not ent   |                             |            |             |          | respiratory a     | arrest, sh | ock, or hea       | art            |                        | nate interval        |
| /Medical  |                | failure. List only one                                    |                      | ach line.                     | lcohol and                           | drug           | Mornhii                     | o and      | cocat       | ino) -   | intovic           | ation      |                   |                |                        | n Onset and<br>Death |
| Examiner  |                | Immediate Cause (Final d<br>or condition resulting in de  |                      |                               | a consequence of                     |                | TOTPILL                     | le aiu     | · cua       | ue).     | птохтс            | aLIUI      |                   |                |                        |                      |
| , ,   |                |   | h                    | Dac to (0) 40 t               | 2 0011004401100 0                    | .,.            |                             |            |             |          |                   |            |                   |                |                        |                      |
|   | er             | Sequentially list condition<br>if any, leading to immedia |                      | Due to (or as a               | a consequence o                      | of):           |                             |            |             |          |                   |            |                   |                |                        |                      |
|   | min            | cause. Enter Underlying<br>(Disease or injury that init   |                      |                               |                                      |                |                             |            |             |          |                   |            |                   |                |                        |                      |
| d<br>sit  | Examiner       | events resulting in death)                                |                      | Due to (or as a               | a consequence o                      | of):           |                             |            |             |          |                   |            |                   |                |                        |                      |
| Division of Vital Records, P.O. Box 68760, the Ilospital or Attending Physician: The law requires that the death certificate be executed fin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and npletely filled in by the funeral director, page 2 should be detached for use as the burial - transit  |                |   |                      |                               |                                      |                |                             |            |             |          |                   |            |                   |                |                        |                      |
| 760,<br>cate be ex<br>physician   | /Medical       | X UNPENDED  |                      | AMENDED                       | item#23a,                            | PII,27         | 28a-f,                      | erME,      | g857,7      | 7/31/0   | 06 TT             | item       | <del>/</del> 1    |                |                        |                      |
| 760, ficate be g physici sthe buri  | /Me            | IF FEMALE:<br>23b. Was decedent pregna                    | nt in the            | 23c. If yes,                  | outcome of preg                      | nancy          |                             |            |             |          |                   | 23         | 3d. Date of       |                |                        |                      |
| 68°<br>certifi<br>iding   | ian            | past 12 months?   | in in the            | 1 Live                        | birth<br>nant at time of de          | 2              |                             |            | Ectopic     | pregnan  | су                |            | Month             | D              | ay                     | Year                 |
| Box 687 ne death certific the attending pred for use as the   | sician         | 1 Yes 2 No 9  | Unknow               | n 4 Pregi                     |                                      | 5              | Other (Spe                  | cify)      |             |          |                   |            |                   |                |                        |                      |
| O. B<br>t the da<br>by the<br>ached   | Phys           | Part II. Other significant                                | conditions           |                               |                                      | esulting in t  | ne underlying               | cause di   | ven in Pa   | rt I.    | 23e. Dio          | tobacco    | use contri        | bute to t      | the cause of           | of death?            |
| , P.O. res that the signed by be detact   | Š              | Cerebral  |                      | _                             |                                      |                |                             | , 3        |             |          | 1 7               | es 2       | ✓ No 3            | Prob           | ably 4                 | Unknown              |
| S,  <br>guires<br>en sig  | ed             |   | Vaccar               | ar accide                     |                                      |                |                             |            |             |          | 24a. Wa           |            |                   |                |                        | ngs available        |
| cords,<br>law requir<br>has been a  | Completed      |   |                      |                               |                                      |                |                             |            |             |          | aut               | topsy      | р                 | rior to c      |                        | of cause of          |
| ec.<br>he la<br>ate ha  | 틍              |   |                      |                               |                                      |                |                             |            |             |          |                   | rformed?   |                   | leath?<br>✔ Ye | s 2                    | No                   |
| tal Rec<br>ian: The<br>certificate  | Ü              | 25. Was case referred to                                  | nedical              |                               |                                      |                |                             | 26.Place   | of Death (  | Check or | nly one)          |            |                   |                | -                      |                      |
| Division of Vital Records, tal or Attending Physician: The law requiral at a fair death.  Is Director: After this certificate has been sted in by the funeral director, page 2 should I   | ) B            | examiner?   |                      | Hospital:                     | Inpatient 2                          | ER/Outpat      | ent 3                       | OOA        | Other;      | Nursing  | Home 5            | Resid      | lence 6           | Other          | : Scene                |                      |
| of V<br>g Phy<br>eral c   | ⊢              | 27. Manner of Death                                       |                      | 28a. Date                     | e of Injury<br>h, Day,Year)          | 28b. Time      | of Injury                   | 28c. Injur | y at Work   | ? :      | 28d. Describ      | e how in   | jury occurr       | ed             |                        |                      |
| on on on the control of the control | io             | 1 Natural 5   | Pending              |                               | h, Day,Year)<br>/10/2006             | Fnd 6:         | 35 mm                       | 1 Y        | es 2 x      | No       | unk               |            |                   |                |                        |                      |
| ivisior<br>or Attend<br>after death<br>Director:<br>I in by the   | g              | 2 Accident  | Investiga            | tion 200 Pla                  | ce of Injury - At h                  |                | _                           | office by  | ulding etr  | 2 2      |                   | (Street    | and Numbe         | er or Rui      | ral Route N            | lumber, City         |
| Jivi<br>I or<br>I Dir<br>ed in  | Certification: |   | Could no<br>determin | t be                          | 17.11                                | l: resid       |                             | , 011100 B |             | "   i    | Baltin            |            |                   |                |                        |                      |
| Spits<br>hours<br>mera<br>y fille   | ပီ             | 4 Homicide  |                      | (Op con)                      |                                      |                |                             |            |             |          |                   | •          |                   |                |                        |                      |
| Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the   | edical         | (Check only Certif  |                      |                               | st of my knowled<br>of examination a |                |                             |            |             |          |                   |            |                   |                |                        |                      |
| To th<br>withii<br>comp   | edi            |   |                      | and manner                    | stated.                              | 3110/01 111403 |                             |            |             |          | are arrie, de     |            |                   |                |                        | <u> </u>             |
|   | Σ              | 29b. Signature and title of                               | certifie             | /                             | //_                                  |                | 29                          |            | number      |          |                   | l          | . Date sign       |                | nth, Day, Ye           | ear)                 |
|   |                | XW I  | AL                   | 1                             |                                      |                |                             | O.C.N      | И.E.        |          |                   | Jul        | y 11, 20          | 06             |                        | [                    |
|   |                | 30. Name and address of                                   | person who           | completed cau                 | use of death (Item                   |                |                             |            |             |          | -                 |            |                   |                |                        |                      |
|   |                | Susan Hogan M   | ). Ass               | istant Medi                   | cal Examine                          | r 111 F        | enn Stre                    | et, Balti  | more, N     | /ID 212  | :01               |            |                   |                |                        |                      |
| S   | tate           |   |                      |                               | Registrar's Signat                   | ure            | (I)                         |            |             |          |                   |            | ·                 |                |                        |                      |
| Regis   |                |   | 2008                 | 180                           | ABUS AS                              | 13/3/11        |                             |            |             |          |                   |            |                   |                |                        |                      |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1 au lor /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death, Examiner Genera Baltimore ary kind Tal If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F 247.44.6522 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28s-f show MD the Medical Examiner must be notified at NIA Baltimore 1ĕYes 2□No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 Glanmore Avenue 230 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 XYes 2 □ No If Yes, Give Year or Dates: 6 1 ☐ Yes 2 No Black ð Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other then "na eny injury or other treumatic event, the Maula 2006. College (1-4or 5+) Elementary/Secondary (0-12) leth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bailer Frazier lautor 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cometery, crematory or other place) Balto. MD 21206 Apt. 10 20a. Method of Disposition 1 St Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State garrison Forest Owing Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Explity Property English Funeral Envices 4013 York Road Baltimore MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Cancer with Metastasis to Liver Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical cutropenia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical signed by the ettending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No After this certificate has been si funeral director, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA To the Hospital or Attending PP within 24 hours efter death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

21215-0036

Maryland

Baltimore,

Box 68760.

P.O.

Records,

of Vital

Division

State Registrar

0

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SomeRo

32. Registrar's Signature

|  |                | 1 - State of Marylan   |                                  | artment of Hertificate of E                    |  | lental Hygie                                   | 2000                                   | 22771   |
|--|----------------|--|----------------------------------|--|--|--|--|---|
| Dhusi  | aia.           | 1. Decedent's Name (First, Middle, Last)   |                                  |  |  | 2. Date of Death<br>Month                      | Day Year                               | 3. Time of Death                                    |
| Physic<br>/Med   |                | Robert Tariton   |                                  |  |  | July 17  | 2006                                   | 11:20 A <sup>M</sup>                                |
| Exam   | iner           | 4a. Facility Name (If not institution, give street and number)   |                                  | 4b. City, Town, or                             |  |  | 4c. County of Dea                      |   |
|  |                | 10535 York Rd. 5. Social Security Number 6. Sex 7. Age (In yrs.  | last hirthday)                   | Cocke  | ysville<br>If Under 24 Hrs.  | 8. Date of Birth                               | Baltime                                | ore<br>hplace (State or Foreign                     |
| Funera<br>Directo  |                | 194-26-7952 X 91   | Yrs.                             | Months Days                                    | Hours Min.   | (Month, Day, Ye Aug. 8 1                       | ear) C                                 | ou <i>ntry)</i>                                     |
| P _  |                | Usual Residence of Decedent  | y, Town or Lo                    |  |  |  |  |   |
| anyla<br>how   | 2              |  |                                  |  |  |  |  | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No              |
| the M  | Director       | MD Baltimore C   | ockeys                           | 10f. Zip Code                                  |  | 100.   | Citizen of What C                      | Χ   |
| 3a or  | ā              | 10535 York Rd.   |                                  | 21030  |  |  | USA                                    |   |
| death  | Funeral        | 11. Marital Status 12. Was Decedent Ever in U. Armed Forces?   | .S. 13. \                        | Was Decedent of His<br>f Yes, specify Cubar    | spanic Origin? (Sp   | ecrfy Yes or No-                               | 14. Race - Am<br>Black, Whi            |   |
| .0036<br>hours effer death with the Maryland<br>turel; or flems 23s or 28s-f show<br>al Estribusing the notilised at   |                | 1 Never Married 2 Married 1 Y Yes 2 No   |                                  |  | Specify:   | Tributi, Sto.)                                 |  | white   |
| 215-0036<br>thin 72 hours efter death with the Marylan<br>en "naturel", or Items 23a or 28e-f ehow<br>Madical Examinar must be notified at   | ed by          | 3 Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education  | 16a Decer                        | dent's Usual Occupa                            | tion   | 161  | o. Kind of Business                    | -/Industry  |
| 1215-<br>within 72<br>ene.<br>then "nat  | plete          | (Specify only highest grade completed)   | (Give                            | kind of work done di<br>DO NOT use retired)    | uring most of work   | ing  | 7. Killa of Dasilless                  | sindustry   |
| _ 35 = 2   | Completed      | Elementary/Secondary (0·12) College (1-4or 5+)  12 n/a   | Con                              | sultant  |  |  | Cable Tel                              | evision   |
| be filed tal Hyging of other   | Be (           | 17. Father's Name (First, Middle, Last)  |                                  |  |  | e (First, Middle, Mai                          | ŕ                                      |   |
| aryla<br>should to<br>and Ment<br>market   | 2              | William Tarlton  |                                  |  |  | y Edith B                                      |  |   |
| ire, Maryland<br>s 1 and 2 should be file<br>if Health and Mental Hy<br>Item 27 is marked oth  |                | 19a. Informant's Name/Relationship (Type, Print) William R. Tarlton/son  |                                  |  |  | a <i>l Route Number, C</i><br><b>Dr., Phoe</b> |  |   |
| A REE  |                | 20a. Method of Disposition 20b. P  |                                  | sition (Name of<br>natory or other place       |  | -  | . Location - City o                    |   |
| Pages nent of nut: If it it ury or o   |                | 1 M Burial 2   Cremation 3   Hemoval from State  |                                  |  | 1  | 21/06 St                                       | ımmit Hil                              | I. PA   |
| alti<br>mait.<br>Porte<br>y inju   |                | 21. Signature of Fundat Scrvice Licensee   | 20                               | Name and Address                               | a of English   |  |  |   |
| <b>n</b> && <b>E a</b> 8   |                | Lowell M. Lemmon   | 1                                | 0 W. Pad                                       | lonia Rd.  | ome of Du<br>, Timonic                         | im, MD 2                               | lley, Inc.<br>21093                                 |
|  | P.             | 23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.  |                                  |  |  | or respiratory arrest,                         |  | Approximate<br>Interval Between<br>Onset and Death  |
| Physician  |                | Immediate Cause (Final disease or condition resulting in death)  a.   Ocuta m  Due to (or as a conseq  | poar                             | dial infe                                      | arction  |  |  | hours   |
| /Medica<br>Examine   |                |  |                                  | V  |  |  |  | 1 00 15   |
|  | <b>ē</b>       | Sequentially list conditions. If any, leading to immediate  b. in poster  or as a consequence of the conditions of the c | uence of):                       |  |  |  |  | Zuars   |
| on site of   | Examine        | cause. Enter Underlying Cause (Disease or injury that initiated events   | E MA                             | not di   | Ricon.   |  |  | Sears   |
| 760, 760 te be executed ysicien and le burial-transit  | Exe            | resulting in death) Last Due to (or as a con   | uence of):                       |  |  |  |  | 0   |
| 2 2 2 2  | licai          | d  |                                  |  |  |  |  |   |
| D # D g  | /Me            | IF FEMALE: 23c. If yes, outcome of pregna  | incv                             | -,55.5   | Alfred State of the State of th |  | God Data of de                         | ,<br>-  |
| .O. Box 68 the death certifica y the attanding pt  | Physician/Med  | in the past 12 months?   | Ideath 3□                        | Ectopic pregnancy Other (specify)              |  |  | 23d. Date of de<br>Month               | Day Year  |
|  | hysi           | 1 Yes 2 No 9 Unknown 9 Unknown   |                                  | ,,,  |  |  |  |   |
| <u> </u>   | by P           | Part II. Other significant conditions contributing to death but not res  | ulting in the u                  | nderlying cause give                           | n in Part I.   | 23e. Did tobac                                 | co use contribute t                    | to the cause of death?                              |
| cords, w requires to been signed should be   |                |  | -                                |  |  | 1 Tes  | 2 No 3 P                               | Probably 4 DUnknown                                 |
| Records, The law requires te has been signe  | Completed      |  |                                  | <del></del> .                                  |  | 24a. Was an autopsy                            | prior to                               | utopsy findings available<br>completion of cause of |
| Vital Rec<br>sicion: The law<br>certificete has b<br>irector, page 2 s   | S              |  |                                  |  |  | performed                                      | i? death?<br>No 1 ☐ Ye                 | s 2□No  |
| Division of Vital or Attending Physicien: Tatler death. Director: After this certificet in by the funeral director, p  | Be             | 25. Was case referred to medical examiner?  Hospital:  |                                  | Othe   |  | h Check only one)                              |  |   |
| Of<br>Phys<br>r this   | 5:1            | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐  27. Manner of Death 28a. Date of Injury (Month, Day Year)  | 28b. Time of                     | IL 3 DOA                                       | 4 🗆 Nursing no   | me 5 Residenc<br>28d. Describe how             |  | ecify)  |
| Vision of<br>Attending Phirideath.<br>ector: Alter thi<br>by the funeral   | Certification: | f Statural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation  | Injury                           |  | ?<br>fes 2 □No   |  |  |   |
| Division of or Attendir s after death. I Director: Att   | III C          | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Specif   | ome, farm, str                   | eet, factory, office                           |  | 28f. Location (Stree<br>City or Town, S        | t and Number or F                      | Rural Route Number,                                 |
| Distance in safe of in its afe in |                |  |                                  |  |  |  |  |   |
| Div<br>To the Hospital or A<br>within 24 hours after<br>To the Funaral Dire<br>completely filled in by   | edical         | 29a. Certifier Check only one)  29a. Certifying Physicien: To the best of my known one control of the basis of examinar and manner stated.   | wledge, death<br>ition and/or in | h occurred at the tim<br>vestigation, in my op | e, date and place,<br>pinion, death occur  | and due to the caus<br>red at the time, date   | e(s) and manner a<br>and place, and du | is stated.<br>le to the cause(s)                    |
| o the<br>ortho<br>omple  | Med            | 29b. Signature and title oncertifier   |                                  | 29c. License                                   |  |  | Date signed (Mon                       |   |
| - s + 6  |                | I De Heron   | M.D.                             | D 60   | 4063   | 4  | 7/19/202                               | 77  |
| 154  |                | 30. Name and address of person who completed cause of death (Item  | n 23a) (Type,                    | Print)   |  | 4  | 1.                                     | MD 21218  |
| 10   |                | JOSELITO M. CABACAR MD.  | 200 E                            | . 33RD   | Street, 2  | +523, BA                                       | HIMORY,                                | MD 21218  |
| Regis  | State          | 31. Date filed (Month, Day, Year)  32. degistrar's Signa  JUL 2 0 2006   | TUE WILLES                       | on all B                                       |  |  |  |   |
| riegis   | Arei           | OUL DO LOOD JAMESTEE   | P. 15                            | San San San San San San San San San San        |  |  |  |   |

|                            |  |                   | 1 - State of Maryland .   | / Department of Health and I<br>Certificate of Death                           | Mental Hygiene                                    | 2006 22772  |
|----------------------------|--|-------------------|---|--|---|---|
| B                          | Physici  | an                | Decedent's Name (First, Middle, Last)  Tavon  | Williams Jr.   | 2. Date of Death  Month Day                       | 3. Time of Death  |
| y .                        | /Medic<br>Examin   |                   | 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hosp   | 4b. City, Town, or Location of Death   | 40.   | County of Death   |
|                            | Funeral<br>Director  |                   | 5. Social Security Number  N/A  11√2 M 2□ F  7. Age (In yrs. last 11√2 M 2□ F   | birthday If Under 1 Year If Under 24 Hrs.  Wonths Days Hours Min.  2           | (Month, Day, Year)                                | 9. Birthplace (State or Foreign Country) MD   |
|                            | ryland<br>how  |                   | 10a. State 10b. County 10c. City, T   | own or Location  |   | 10d. Inside City Limits   |
|                            | death with the Maryland<br>ima 23a or 28a-f ehow<br>r must be cotified at  | Funeral Director  | MD NA Bal   | timore   | 10-07   | 1 X Yes 2 No  |
|                            | 3a or 3  | I Di              | 716 Lenox Street  | 10f. Zip Code 21217  | Tog. Citi.  | zen of What Country?  |
|                            | r death  | Iner              | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?   | 13. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puert | pecify Yes or No-<br>to Rican, etc.)              | 14. Race - American Indian,<br>Black, White, etc.   |
| 336                        | ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hydens. If item 27 is marked other than "naturel", or itema 23a or 28a-f show or other treumatic event, the Madical Examination in that he collined at  | by F              | Married 2 Married 1 Yes 2 No If Yes, Give 1 Serviced 1 Yes 2 No If Yes, Give 1 Year or Dates:   | 1 ☐ Yes 2 ☑ No Specify:  |   | Specify: Black  |
| 5-0                        | 72 hor   | eted              | 15. Decedent's Education (Specify only highest grade completed)   | 6a. Decedent's Usual Occupation (Give kind of work done during most of work    | rking 16b. Kin                                    | nd of Business/Industry   |
| 21215-0036                 | e filed within<br>al Hygiene.<br>I other than '  | Completed         | College (1-4or 5+)   N / A  | life. DO NOT use retired) N/A  |   | N/A   |
|                            | be filed<br>stal Hygi<br>od other<br>event, I  | Be C              | 17. Father's Name (First, Middle, Last)   | 18. Mother's Nan   | me (First, Middle, Maiden                         | Surname)  |
| Maryland                   | should ind Menind  은                 | Tavon Williams Sr.  19a. Informant's Name/Relationship (Type, Print)  | Chemia 19b. Mailing Address (Street and Number or Ru                           |   | Town State Zin Code   |
|                            | and 2 sho<br>salth and<br>n 27 ie m  |                   |   | 716 Lenox Street,  |   |   |
| Baltimore,                 | Pages 1 and of He out. If item iry or other  |                   | 20a. Method of Disposition 1 ☐ Burial 2€Cremation 3 ☐ Removal from State  20b. Place certain  | e of Disposition (Name of etery, crematory or other place)                     | Date 20c. Lo                                      | cation - City or Town, State  |
| Itim                       | t. Partment  |                   | 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee   | o Crematory Inc 7  | /20/06 B  | altimore, Md  |
| Ba                         | Depa<br>Impo   | _                 | Thannon Haham   | March F/H West<br>4300 Wabash Ave  | , Baltimor  | e, Md 21215   |
|                            | Physician  |                   | 23a. Part 1. Enter the disease, or complications that caused the death. If shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition   | Do not enter the mode of dying, such as cardiac                                |   | Approximate<br>Interval Between<br>Onset and Death  |
| 8760,                      | death certificate be executed  e attending physicien and of for use as the burial transit  | icai Examiner     | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence)  Due to (or as a consequence)  Due to (or as a consequence) | Pre maturity   | dome  | 2 days  |
| .O. Box 6                  | the death certifi<br>y the attending p<br>iched for use as   | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown  | ath 3 Ectopic pregnancy  | 2   | 3d. Date of delivery<br>Month Day Year  |
| rds, P.                    | w requires thet<br>been signed b<br>should be deta   | Ď                 | Part II. Other significant conditions contributing to death but not resulting   | ig in the underlying cause given in Part I.                                    | - C   | se contribute to the cause of death?  |
| Division of Vital Records, | The law<br>ete has b<br>page 2 s   | Completed         |   |  | 24a. Was an autopsy performed?                    | 24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No |
| Vita                       | Physicien: T<br>this certificel<br>al director, p  | Be                | 25. Was case referred to medical examiner?  1 □ Yes 2 ₹ No Hospital: 1 ▼ Invatient 2 □ ER   | Othor  | ath (Check only one)                              |   |
| ion of                     | Attending Physic death. ector: After this by the funeral di  | ation: To         | 1   Tes 2 to No 1   1   1   1   patient 2   ER  | /Outpatient 3 □ DOA  | lome 5 Residence 6<br>28d. Describe how injury    |   |
| Divis                      | ai or Attendi<br>s after death.<br>il Director: A<br>id in by the fu   | Certification:    | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)   | i, farm, street, lactory, office   | 28l. Location (Street and<br>City or Town, State) | i Number or Rural Route Number,   |
|                            | To the Hospital or Attending Pr<br>within 24 hours after death.<br>To the Funerel Director: After th<br>completely filled in by the funeral  | edicai (          | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowle Medical Examiner: On the basis of examination and manner stated.  | and/or investigation, in my opinion, death occu                                | rred at the time, date and                        | place, and due to the cause(s)  |
|                            | To the within 2 To the complete  | Σ                 | 29b. Signature and title of certifier   | 29c. License number  | 29d. Date   | signed (Month, Day, Year)   |
| ,                          | á  |                   | 30. Name and address of person who completed cause of death (Item 23  | Ray (Type Print)   | UU Ji   | ly 18, 2006   |
|                            | 4  |                   | Corne keet MD The Johns   | Hookins Hospital 6   | 200 Wolfe   | St Balto MD 2834  |
| 1                          | Sta<br>Registi   |                   | 31. Date filed (Month, Day, Year)  32. Registrar's Signature  JUL 2 0 2006  | 29c. License number  RES-0  Ba) (Type, Print)  Hopkins Haspital 6              |   | ,   |

|  |                     | For<br>State<br>Registrar  |   | Marylan                                   |                                       | artmen<br>tificate                      |                        |                                       |                          |  | Reg. No.              | 006                                     | 22773   |
|--|---------------------|--|---|---|---------------------------------------|---|------------------------|---------------------------------------|--------------------------|--|-----------------------|---|---|
| Physicia   |                     | 1. Decedent's Name (First, Middle LULA   | WILSON  |   |                                       |   |                        |                                       |                          | 2. Date of Dea<br>Month  | Day                   | Year<br>200                             | 3. Time of Death 5:20 PM                                  |
| /Medic<br>Examin   |                     | 4a. Facility Name (If not institution  | n, give street and num                                    |   |                                       |   |                        | Location o                            |                          |  | 4c. C                 | ounty of Deat                           | -   |
| Funeral<br>Director  |                     | 5. Social Security Number 213-34-8594  |   | 7. Age (In yrs. I                         | a <i>st birthd</i> ay)<br>Yrs.        | If Under<br>Months                      | 1 Year<br>Days         | If Under a                            | Min.                     | 8. Date of Birt<br>(Month, Da  | th<br>y, Year)<br>36  | Co                                      | hplace (State or Foreign<br>untry)                        |
| iryland<br>show  |                     | Usual Residence of Decedent  10a. State  10b. County   |   |   | , Town or Lo                          |   |                        |                                       |                          |  |                       |   | 10d. Inside City Limits                                   |
| the Ma   | recto               | MD N   | A   | Bal                                       | timor                                 | 10f. Zip                                | Code                   |                                       |                          |  | 10g. Citize           | n of What Co                            | XXYes 2 □ No<br>untry?                                    |
| 138 of 1   | ai Di               | 2409 Dumfrie   | s Ct.   |   |                                       |   | 212                    | 30                                    |                          |  |                       | U.S.A                                   | •   |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene. Important: If them 27 is marked other than "neturel", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at once. | by Funeral Director | 11. Marital Status  1 Never Married 2 Mar  Widowed 4 Divorced  | ned 1 Tes   | 2 TVNo                                    |                                       | Was Deced<br>f Yes, spec<br>1 ☐ Yes 2   |                        | spanic Orig<br>n, Mexican<br>Specify: | gin? (Spe<br>, Puerto F  | cify Yes or No<br>Rican, etc.)   |                       | . Race - Ame<br>Black, White<br>pecify: |   |
| netur  | Completed           | 15. Deceder<br>(Specify only highe   | nt's Education<br>est grade completed)                    |   | 16a. Deced                            | dent's Usua<br>kind of wor<br>DO NOT us | k done di              | urina most                            | of working               | ng   | 16b. Kind             | of Business/                            |   |
| d withir<br>d withir<br>giene.   | omo                 | Elementary/Secondary (0-12)<br>8th grade   | College (1-   | ·4or 5+)                                  |                                       | Care                                    | ,                      |                                       | er                       |  | Self                  | Empl                                    | .oyed   |
| should be file and Mental Hyg  | To Be C             | 17. Father's Name (First, Middle, Cleve Willia   | Last)   |   | •                                     |   |                        |                                       |                          | (First, Middle,<br>Sewel   |                       | umame)                                  |   |
| end 2 sho<br>eath and I<br>m 27 is ma  |                     | 19a. Informant's Name/Relations<br>Claudia Braxt   |   | ter                                       | 19b. Mailir<br>1313                   | ng Address<br>Meri                      | (Street a              | <sup>nd Numbe</sup><br>e Dr           | r or Rura<br>ive         | Route Number   | er, City or 1         | own, State, Z                           | Zip Code)<br>1 21239                                      |
| Pages 1 er<br>nent of Hea<br>mt: # Nem 3<br>ury or other   |                     | 20a. Method of Disposition 1    Burial 2 □ Cremation   | 3 □Removal from S   | 20b. P                                    | Lace of Dispo<br>emetery, crer        | natory or o                             | ther place             | .                                     |                          | ate  |                       | ition - City or                         |   |
| permit. P. Depertme Important any Injury 2005  | i                   | 4 □Donation 5 □Other (S  |   | Kir                                       |                                       | . Name an                               | d Addres               | s of Facility                         | y                        | 1/06   | Ranc                  | lallst                                  | own, Md   |
| 0 88 5 8   |                     | manne  | mod   | 1aha                                      | 4                                     |   | √aba                   | sh A                                  | ve,                      | Balti  |                       | , Md                                    | 21215   |
| Pnysician<br>/Medical  |                     | 23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) | t only one cause on ea                                    | PIRATO                                    | DRY I                                 |   | ,                      |                                       | cardiac oi               | r respiratory ar   | rest,                 |   | Approximate Interval Between Onset and Death Ihrteen days |
| Examiner   | e                   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                    | b   | ur as a cunsequ                           |                                       |   |                        |                                       |                          |  |                       |   |   |
| te be executed spicion and se burial-transit   | ical Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                | c   | or as a consequ                           | uence of):                            |   |                        |                                       |                          |  |                       |   |   |
| w requires that the death certificate be executed been signed by the ettending physicien and should be detached for use as the burial-transit  | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  |   | nth 2 ☐ Fetal<br>antattime of de          | death 3                               | Ectopic pr<br>Other (sp                 |                        | - 1-7-2                               |                          |  | 23                    | d. Date of deli<br>Month                | ivery<br>Day Year   |
| requires that the seen signed by the hould be detached   |                     | Part II. Dther significant conditi   | ons contributing to de                                    | ath but not resu                          | ulting in the u                       | nderlying ca                            | ause give              | n in Part I.                          |                          |  | obacco use<br>res 2 🗹 | /                                       | the cause of death?                                       |
| - et (2) Ot  | Completed by        | Congestive   | Heart fa  | arlure                                    |                                       |   |                        |                                       |                          | 24a. Was   |                       | 24b. Were au                            | topsy findings available                                  |
| The The page   |                     | Pulmonary  |   | ensior                                    | ).                                    |   |                        |                                       |                          |  | rmed?                 | death?                                  |   |
| UNISION OF ITAL ME HOSPITAL TO THE HOSPITAL OF THE REWIND 24 hours effer death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page 2   | ion: To Be          | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pendi                            | Hospital: 1 Err   | npatient 2  <br>of Injury<br>h, Day Year) | ER/Outpatier<br>28b. Time o<br>Injury | 2                                       | 8c. Injury<br>Work     | r: 4 □ Nu<br>at<br>?                  | rsing Hom                | (Check only one 5 Residence 18d. Describe for the control of the c | dence 6[              |   | enty)   |
| DIVISION  or Attending setter death. If Director: Atte d in by the fune  | Sertification:      | 3 Suicide 6 Could  | nined 286. Place  | of Injury - At ho<br>ng, etc. (Specify    |                                       | eet, factory                            |                        | ′es 2 □ !                             |                          | 8f. Location (5<br>City or Tox   |                       | Vu <i>mber of R</i> u                   | ıral Route Number,  |
| To the Hospital or Al<br>within 24 hours after of<br>To the Funerel Direc<br>completely filled in by   | edical C            | 29a. Certifier 1 Certifyi (Check only one) 1 Medical   | ng Physician: To the<br>I Examiner: On the ba<br>and mann | isis of examinat                          | wladge, deall<br>tion and/or in       | vestigation                             | at the tim<br>in my op | e, data an<br>inion, deal             | d place, a<br>th occurre | nd dua to the od at the time,  | date and pl           | d manner as<br>lace, and due            | stated.<br>to the cause(s)                                |
| To the To the Comp   | ž                   | 29b. Signature and title of certific   |   | ont                                       |                                       | 1                                       | License                |                                       |                          |  |                       | signed (Monti                           |   |
|  |                     | 30. Name and address of person   | - Reside  |   | 23a) /Tune                            |   |                        | 000                                   |                          | LA MICOLE  |                       | Y 13                                    |   |
| H  |                     | AMUSA NTA  | ATIN: HA  | ARBOR                                     | HOSP                                  | ITAL                                    | <u></u>                | SALT                                  | 1M                       | ore,   | MA                    | JII CET                                 | 1   |
| Sta<br>Registr   |                     | 31. Date filed (Month, Day, Year JUL 2 0   | 2006 32/Re  | egistrar's Signa                          | ture                                  | de                                      |                        |                                       |                          |  |                       |   |   |

06-04952 Eric Willie

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

| ric vville   |                | - For State                                 | St                                      | ate of Maryland  |              | tificate of                         |   | id Ment            |                                   | g No.        | 200                   | 6 2277                                    |
|--|----------------|---|---|--|--------------|-------------------------------------|---|--------------------|-----------------------------------|--------------|-----------------------|---|
| Physician  | 1              | e <b>gistrar</b><br>. Decedent's Name       | (First, Middl                           | e,Last)  | -            |                                     |   |                    | Date of Deat     Month            | h<br>Dav     | Year                  | 3 Time of Death<br>1924 hrs               |
| Medical Examine  |                | ERIC  | not institutio                          | n, give street and number)                             |              | WIL                                 | LIE<br>b. City, Town, c                 | r Location of      | July 11, 20                       |              | ounty of Death        |   |
|  |                | Maryland Ge                                 |   |  |              |                                     | Baltimore                               |                    |                                   |              | NA                    |   |
| Funeral  | į              | 5. Social Security N                        |   | 6. Sex 7. Ag   | e (In yrs la | st birthday)                        | If Under 1 Ye Months Da                 |                    | 24Hrs. B. Date of Birt            | ,            | Foreig                | thplace (State or<br>gn                   |
| Director   |                | 212-70-6                                    |   | 1 <b>X</b> M 2 F                                       | 47           | Yrs.                                | WOTTIS                                  | ys Tiouis          | 09-08                             | 3–195        | 8 0                   | untry) Md.                                |
| sue .  |                | Jsual Residence of<br>10a. State            | Decedent<br>10b. County                 |  | 10c. City,   | Town or Location                    | on                                      |                    |                                   |              |                       | 10d Inside City Limits                    |
| ž  | _              | Md.   | NA                                      |  |              | Baltimo                             | ore                                     |                    |                                   |              |                       | 1 X Yes 2 No                              |
| th the Maryland 23a or 28a-f show notified at once.  | Director       | 10e. Street and Nur                         | nber                                    |  |              |                                     | 10f. Zip Code                           |                    | 11                                | 0g. Citizen  | of What Cou           | ntry?                                     |
| th the 23a or notifie  | <u> </u>       | 8372 Chu                                    | rch La                                  | ne<br>12. Was Decedent                                 | Ever in 115  | S 13 W/29                           | 21244                                   |                    | in? ( Specify Yes or No           | US<br>L14    |                       | ican Indian, Black,                       |
| items  | runeral        | 1 X Never Marrie                            | ed 2 M                                  | arried Armed Forces?                                   |              |                                     |   |                    | Puerto Rican, etc.)               |              | White, etc            |   |
| after d  | 드<br>참<br>-    | 3 Widowed                                   |   | orced If Yes, Give Year or Dates:                      |              |                                     | Yes 2 X N                               |                    |                                   |              | <sub>ecify:</sub> Bla |   |
| hours natur  | - E            | 15. Decedent's Ed                           |   | cify only highest grade con<br>College (1-4 or         |              |                                     | 's Usual Occup-<br>ost of working lif   |                    | ind of work done<br>use retired)  | 16b, Kind    | d of Business/        | Industry                                  |
| 215-0036 be filed within 72 hours after that Hygiene fred other than "natural" ent, the Medical Examine  | Completed      | GED   | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 10.0031  |              | Press                               | operat                                  | or                 |                                   | Park         | Lane :                | Press                                     |
| 21215-0036 Juid be filed within 7 Mental Hygiene marked other than re event, the Medica  |                | 17. Father's Name (                         | First, Middle                           | Last)  | •            | Whit∈                               |   |                    | s Name (First, Middle, M          | Aaiden Su    | rname)                | D 7                                       |
| 2121<br>uld be fil<br>Mental I<br>marked   | 90             | 19a. Informant's Na                         | me/Relations                            |  |              |                                     | **************************************  | UID-4-3 VALS       | orraine<br>ber or Rural Route Num | nber, City o | or Town, State        | Reed<br>, Zip Code)                       |
| and 2 shou tealth and N tem 27 is n traumatic  | 1              | Pam Will                                    | ie                                      | Sister   |              |                                     |   |                    | Baltimore                         |              | 212                   |   |
| <u> </u>   |                | 20a. Method of Disp<br>1 Burial 2           |   | n 3 Removal from St                                    |              | Place of Disposi<br>rematory or oth |   | emetery,           | Date                              | 20c. Loc     | ation - City or       | Town, State                               |
| Baltimo<br>permit. Page<br>Department of<br>Important:<br>injury or out  |                | Λ   | Other S                                 | pecify.  | Mt           | . Carme                             | el Cem.                                 | as of Escility     | 7-19-06                           |              | ndalk,                |   |
| Balt permit. Depart Impor  |                | 21, Signature of Fu                         | neral Service                           | 2 W arri   |              |                                     | ame and Addre                           | -                  |                                   |              | re, Md<br>rth Ave     |   |
| Physician  | +              | 23a Part I. Enter th                        |   | complications that caused on each line.                | the death.   | Do not enter th                     | ne mode of dying                        | g, such as ca      |                                   |              |                       | Approximate Interval<br>Between Onset and |
| /Medical<br>xaminer  |                | Immediate Cause (<br>or condition resulting | Final disease                           | a. Narcotic  |              |                                     |   |                    |                                   |              |                       | Death                                     |
| 2  |                | Sequentially list co                        |   | Due to (or as a cons                                   | equence of   | <i>1</i> ·                          |   |                    |                                   |              |                       |   |
|  | <u>l</u> e     | if any, leading to in<br>cause Enter Under  | nmediate<br>erlying Cause               | Due to (or as a cons                                   | equence of   | F):                                 |   |                    |                                   |              |                       |   |
| p it   | Examiner       | (Disease or injury t<br>events resulting in |   | Due to (or as a cons                                   | equence of   | f):                                 | -                                       |                    |                                   |              |                       |   |
| wecute<br>n and<br>1 - tran  |                | X UNPENDED                                  |   | damended it  | em#23a       | ,27,28a-f                           | .perME.e8                               | B57.7/26           | 5/06 TT                           |              |                       | -   |
| 760, icate be executed physician and the burial - transit  | Medical        | IF FEMALE:                                  |   | 23c. If yes, outco                                     |              |                                     | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 337,77             |                                   | 23d E        | ate of deliver        | y   |
| 687<br>certific<br>ding p  |                | 23b. Was decedent<br>past 12 months         |   | 1 Live birth  Pregnant a                               | t time of de | nah -                               |   | Ectopic            | pregnancy                         | Mo           | onth I                | Day Year                                  |
| Division of Vital Records, P.O. Box 687  To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2. | Physician/     | 1 Yes 2                                     | No 9 Un                                 | ,  |              | 5 Oti                               | ner (Specify)                           |                    |                                   |              |                       |   |
| Records, P.O. I  | <u>ا</u> ه     | Part II. Other sign                         | ificant condi                           | tions contributing to deat                             | h but not re | esulting in the u                   | nderlying cause                         | given in Pa        |                                   |              |                       | tne cause of death?                       |
| aprires 1  |                |   |   |  |              | <u>_</u>                            |   |                    |                                   | -            |                       | utopsy findings available                 |
| COTC<br>law rea<br>has be  | Completed      | -   |   |  |              |                                     |   |                    | autop<br>perfo                    | rmed?        | prior to death?       | completion of cause of                    |
| Retificate   |                | 25. Was case refer                          | red to medic                            | ai T   |              |                                     | 26.Pla                                  | ce of Death        | (Check only one)                  | 2 No         | 1 🗸 Y                 | es 2 No                                   |
| Vita<br>sysician<br>this cer   | e Be           | examiner?                                   | 2 No                                    | ( lossitely  | ent 2 🗸      | ER/Outpatient                       | 3 DOA                                   | Other <sub>4</sub> | Nursing Home 5                    | Residence    | e 6 Othe              | r.  |
| Ing Pt   | Ë              | 27 Manner of Dea<br>1 Natural               |   | 28a. Date of Inj<br>(Month, Day,                       | Year)        | 28b Time of I                       |   | ijury at Work      | No.                               | how injury   | occurred              |   |
| ivisior I or Attend after death Director:  | ğ              | 2 Accident                                  | Inve                                    | estigation Fnd 7/11 28e, Place of I                    |              | Fnd 6:50<br>ome, farm, stree        | , Parr                                  |                    | c 28f Location (                  | Street and   | Number or Ru          | ural Route Number, City                   |
| Divi   | Certification: | 3 Suicide 4 Homicide                        |   | ild not be   |              | t bottom                            |   |                    | Baltimore                         | State) 16.   | 12 Vince              | nt Court                                  |
| Division of Vital Brother Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.   |                | 29a Certifier (Check only                   |   | Physician: To the best of naminer: On the basis of exa | ny knowled   | ge, death occur                     | red at the time,                        | date and pla       | ace, and due to the caus          | se(s) and r  | nanner as star        | rted.                                     |
| To the within To the comple  | Medical        | one) 2 🗸                                    |   | and manner stated                                      | ammation a   | ma/or investiga                     |   | nse number         | date                              |              |                       | onth, Day, Year)                          |
|  |                | Zop olgrididi alik                          | 0                                       | 11 1/  |              |                                     |   | C.M.E.             |                                   |              | 2, 2006               |   |
|  |                | 30 Name and add                             | ress of perso                           | n who completed cause of                               | death (Item  |                                     |   |                    |                                   |              |                       |   |
| 5950   |                | Jack Titus                                  |   | puty Chief Medical E                                   |              |                                     | n Street, B                             | altimore, l        | MD 21201                          |              |                       |   |
| Sta<br>Registi   |                | 31. Date filed (Mor                         | th, Day, Year<br>2 0 20                 | 32. Registr  | ar s signati | Seaste .                            | -                                       |                    |                                   |              |                       |   |

|                            |  |                   | For<br>State<br>Registrar  | State of Ma   | ryland / Dep<br><i>Ce</i>             | artment of F<br>rtificate of         |                              |   | giene<br>Rag. No.            | 006                      | 22775  |
|----------------------------|--|-------------------|--|---|---------------------------------------|--------------------------------------|------------------------------|---|------------------------------|--------------------------|--|
|                            | Physici  | an                | 1. Decedent's Name (First, Middle, Las<br>AUDYCU Mae   |   | <u> </u>                              |                                      |                              | 2. Date of De<br>Month                              | Day                          | Year<br><b>O</b> O       | 3. Time of Death                                   |
|                            | /Medio   |                   | 4a. Facility Name (If not institution, give  | street and number)  |                                       | 1                                    | r Location of Dea            |   |                              | nty of Death             | I C CA   |
|                            | Funeral  |                   | 833 W. Pratt<br>5. Social Security Number 6. So  | 7. Age  | ‡3  <br>(In yrs. last birthday,       | If Under 1 Year<br>Months Days       | If Under 24 Hr               |   | th<br>v Year)                | 9. Birthr                | place (State or Foreign                            |
| 4                          | Director   |                   | Usuat Residence of Decedent  | □ M 2 <b>X</b> CF   | 85 Yrs.                               | MOTILIS Days                         | TIOUIS IVIII                 | n. B. Date of Bir (Month, Da                        | 1921                         |                          | VA   |
|                            | ehow   | ō                 | 10a. State 10b. County   |   | 10c. City, Town or Li<br>Balti        |                                      |                              |   |                              |                          | 10d. Inside City Limits 1 (2) Yes 2 □ No           |
|                            | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "naturel", or teme 23a or 28a-f ehow<br>ther the Medical Examinar must be notified at             | Funeral Director  | 10e Street and Number  | t Street  |                                       | 10f. Zip Code                        | 21221                        |   | 10g. Citizen o               | of What Could            | ntry?  |
|                            | me 23a   | nerai I           | 11. Marital Status   | 12. Was Decedent E  |                                       | Was Decedent of I                    | 21201<br>Hispanic Origin?    | (Specify Yes or No                                  | )- 14. R                     | ace - Ameri              |  |
| 36                         | rs after   | by Fur            | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 📉 Divorced   | Armed Forces? 1 ☐ Yes 2 ▼ No lif Yes, Give Year or Dates: | 0                                     | If Yes, specify Cub<br>1 ☐ Yes 2 XNo | an, Mexican, Pue<br>Specify: | эпо нісап, есс.)                                    | Spec                         | lack, White,<br>cify: Bl | ack.   |
| 2-00                       | 72 hou<br>nature   | eted              | 15. Decedent's Ed<br>(Specify only highest gra   | lucation  | (Give                                 | dent's Usual Occup                   | during most of w             | rorking   | 16b. Kind of                 | Business/în              | dustry   |
| 21215-0036                 | d within<br>giene.<br>or then  | Completed         | Elementary/Secondary (0-12)  | College (1-4or 5-   | ·) ////                               | Beaut                                |                              |   | H                            | air                      | Care   |
| and                        | d ta b   | To Be (           | 17. Father's Name (First, Middle, Last) John Brown   | , 8r.   |                                       |                                      | 1                            | ame (First, Middle<br>tie) SV                       |                              |                          |  |
| Maryland                   | 12 should<br>h and Men<br>7 ie marke<br>traumatic  | -                 | 19a. Informant's Name/Relationship (   | Type, Print)  |                                       | ing Address (Street                  |                              | -   | · · · · —                    |                          |  |
|                            | of Health  |                   | Delores Goode,<br>20a. Method of Disposition<br>1 1 Burial 2 ☐ Cremation 3 ☐                           | Daught  | 20b. Place of Disp                    | osition (Name of matory or other pla |                              | Date  | 20c. Location                | - City or To             |  |
| Baltimore,                 | iit. Pages<br>artment of I<br>ortant: If its<br>injury or o  |                   | 4 Donation 5 Other (Specif) 21. Signature of Funeral Service Licen                                     | )   | Arbun                                 | S Mems                               | rial of                      | 121/00  |                              |                          | ore MD   |
| Ba                         | permit. Departr Imports any inje   |                   | Hen W.   | Sid   |                                       | aughin                               | C. Green<br>Load             | e Funen<br>Baltimo                                  | e MD 2                       | 21212                    |  |
|                            | Pnysician  | vr ti             | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only<br>tmmediate Cause (Final | olications that caused one cause on each line             | 0 \                                   | ter the mode of dyi                  | ng, such as cardi            | ac or respiratory a                                 | rrest,                       |                          | Approximate<br>Interval Between<br>Onset and Death |
|                            | /Medical<br>Examiner   |                   | disease or condition resulting in death)   | aDue to (or as a  | consequence of):                      | 2 140742                             |                              | 126   |                              |                          |  |
|                            | p ≅  | iner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying                     | b. Due to (3r is a  | consequence of):                      | Lardio                               | mgona                        | 14  |                              |                          | a Sea-s  |
| Ö.                         | execute<br>in and<br>ial-trans   | Examiner          | Cause (Disease or injury that initiated events resulting in death) Last                                | c. Our e  | consequence of):                      | u. o leu                             | 1/404                        |   |                              |                          |  |
| 8760,                      | death certificate be executed<br>e attending physicien and<br>of for use as the burial-transit   |                   |  | d   |                                       |                                      |                              |   |                              |                          |  |
| Box 6                      | certif<br>ding<br>se as  | Physician/Medical | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome of                                   |                                       | ⊒Ectopic pregnanc                    | у                            |   |                              | Date of deliver          | ery<br>Day Year                                    |
| P.O. E                     | that the death<br>hed by the atter<br>detached for u   | hysici            | in the past 12 months?<br>1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown  | 4□Pregnant at t<br>9□Unknown                              | ime of death 5                        | Other (specify) _                    |                              |   |                              | worth                    | Day 16al   |
|                            | law requires that the<br>es been signed by th<br>2 should be detache   | ρ                 | Part II. Other significant conditions of   | ontributing to death bu                                   | -                                     | underlying cause gr                  |                              |   | obacco use co                |                          | he cause of death?                                 |
| cor                        | law requires t<br>as been signe<br>2 should be   | Completed         | Idupe-lipede   | m i u   |                                       |                                      |                              | 24a. Was  |                              |                          | opsy findings available impletion of cause of      |
| al Re                      | ician: The lav<br>certificete hes<br>rector, page 2  |                   | 25. Was case referred to medical   |   |                                       |                                      | /-                           | perfo<br>1 ☐ Yes                                    | 2 No                         | death?                   |  |
| Ž                          | Physician:<br>rthis certific<br>ral director,  | To Be             | examiner?  | Hospital: 1 Inpatier                                      | nt 2 ER/Outpatie                      | nt 3□ DOA Ot                         | 200                          | eath (Check only only only only only only only only |                              | ther (Specif             | (y)  |
| o uo                       | Attending PI r death. ector: After th by the funeral   | tion:             | 27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation                                  | 28a. Date of Injur<br>(Month, Day                         | Year) 28b. Time of Injury             | Wo                                   | ry at<br>rk?<br>] Yes 2 □ No | 28d. Describe                                       | how injury occ               | urred                    |  |
| Division of Vital Records, | i or Attend<br>after death<br>Director:  | Certification;    | 3 Suicide 6 Could not be determined  | 28e. Place of Inju  | ry - At home, farm, si<br>. (Specify) | treet, factory, office               |                              | 28f. Location (<br>City or To                       | Street and Nur<br>wn, State) | mber or Rura             | al Route Number,                                   |
| Ц                          | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificete h completely filled in by the funeral director, page | edical Ce         | 29a. Certifier 1 Certifying Ph   | ysician: To the best on the basis of                      | f my knowledge, dea                   | th occurred at the ti                | me, date and pla             | ce, and due to the                                  | cause(s) and a               | manner as s              | stated.  |
|                            | within 24 To the F To the F complete   | Medi              | one) 29b. Signature and title of certifier   | and manner star   | led.                                  | 29c. Licen                           | -                            |   | 29d. Date sign               |                          | · · · · · · · · · · · · · · · · · · ·              |
|                            | 4  |                   | Linke  | reer  | D                                     | paa                                  | 122                          |   | 7- a                         | 0-04                     |  |
|                            | 3  |                   | 30. Name and address of person who   | 70 419 h  | Redurent                              |                                      | +. 17d a                     | 11201   |                              |                          |  |
| ì                          | Sta<br>Regist  | ate<br>rar        | 31 Date filed (Month Day Year)   | 2006 32. Registra   | r's Signature                         | GORNES                               |                              |   |                              |                          |  |

|                            |  |                   | 1 ← For<br>State<br>Registrar  | State of  | Marylar                   | •                       | artmen<br>tificate     |                    |                            | ınd Me                   |                                 |   | 006   | 22776  |  |
|----------------------------|--|-------------------|--|---|---------------------------|-------------------------|------------------------|--------------------|----------------------------|--------------------------|---------------------------------|---|---|--|--|
| П                          | Observator   |                   | 1. Decedent's Name (First, Middle, Last)   |   |                           |                         |                        |                    |                            |                          | 2. Date of De.                  | ath   |   | 3. Time of Death   |  |
|                            | Physici<br>/Medio  |                   | Gary Charles Wagn  | er  |                           |                         |                        |                    |                            |                          | July                            | 17, Day 2   | 006 <sup>Year</sup>   | 6:45 A M   |  |
|                            | Examin   |                   | 4a. Facility Name (If not institution, give s                                    |   | oer)                      |                         | •                      |                    | Location of                |                          |                                 |   | ounty of Death  |  |  |
|                            |  |                   | 1321 Lafayette Ave   |   | A //-                     | to a tital to 1         | Cato                   |                    | ille N                     |                          |                                 |   | Baltimo   |  |  |
| ı.                         | Funeral<br>Director  |                   | 5. Social Security Number 6. Sex 123-56-2008                                     | M 2□F   | Age (In yrs.<br>56        | Yrs.                    | Months                 | Days               | Hours                      | Min.                     | 8. Date of Birt<br>(Month, Da   | of Birth 9. Birthplace (State or Foreign Country) 26, 1950 Maryland |   |  |  |
| -                          |  |                   | Usual Residence of Decedent  |   | 50                        |                         |                        |                    |                            | р                        | all . 20 ,                      | 1930  | rial y  | Land   |  |
|                            | yland  |                   | 10a. State 10b. County   |   | 10c. Cit                  | ty, Town or Lo          | cation                 |                    |                            |                          |                                 |   | 1   | 10d. Inside City Limits  |  |
|                            | e Ma   | ctor              | Maryland Baltimo   | re  | Cat                       | tonsvil                 | le Ma                  | nor                |                            |                          |                                 |   |   | 1 ☐ Yes 2 💢 No   |  |
|                            | ith th   | Director          | 10e. Street and Number   |   |                           |                         | 10f. Zip               | Code               |                            |                          |                                 | 10g. Citize   | n of What Coul  | ntry?  |  |
|                            | eth w  | ra                | 1321 Lafayette Ave   |   |                           | 0 1                     |                        | 207                |                            |                          |                                 | US  |   |  |  |
|                            | ltem<br>ltem   | une               | 11. Marital Status  1 ☐ Never Married 2 ☒ Married                                | <ol> <li>Was Deceded</li> <li>Armed Force</li> <li>1 ☐ Yes 2</li> </ol> | es?                       | .S. 13. V               | Vas Deced<br>Yes, spec | ent of Hi          | spanic Orig<br>n, Mexican, | jin? (Spec<br>, Puerto R | cify Yes or No-<br>lican, etc.) | - 14.   | Race - Americ<br>Black, White,  |  |  |
| 39                         | urs af   | by Funeral        | 3 ☐ Widowed 4 ☐ Divorced   | If Yes, Give<br>Year or Date  |                           |                         | ☐ Yes 2                | 2[ <b>X</b> No     | Specify:                   |                          |                                 | Sį  | pecify: Wh:   | ite  |  |
| Maryland 21215-0036        | filed within 72 hours after deeth with the Maryland<br>Hygiene.<br>wher than "natural", or Iteme 23a or 28e-f ehow<br>wit, It a Medical Exaculational Le notified at             | Completed         | 15. Decedent's Educ  |   |                           | 16a. Deced              |                        |                    |                            | -4 - 1:-                 |                                 | 16b. Kind   | of Business/In  | dustry   |  |
| 216                        | thin 7   | nple              | (Specify only highest grade<br>Elementary/Secondary (0-12)                       | College (1-4  | or 5+)                    | life. L                 | OO NOT us              | e retired,         |                            | or working               | g                               |   |   |  |  |
| 7                          | ygien<br>ygien<br>t,   | S                 |  | 2   |                           | Ca                      | ble S                  | Splic              |                            |                          |                                 |   | unicati   | lons   |  |
| gue                        | be fill<br>d off   | Be                | 17. Father's Name (First, Middle, Last) Charles Wagner                           |   |                           |                         |                        | İ                  |                            |                          | (First, Middle, P. Mey          |   |   |  |  |
| ž                          | should bind Ment   | ٦                 | 19a. Informant's Name/Relationship (Typ  | na Print)   |                           | 10h Maifie              | a Addross              | /Ctroot o          |                            |                          |                                 |   | own, State, Zip   | 0-4-)  |  |
| <u>⊠</u>                   | d trait  |                   | Christine Wagner   | Wife  |                           |                         |                        |                    |                            |                          |                                 | _   |   | MD 21207   |  |
| ē,                         | s 1 and 3<br>I Health<br>Item 27<br>other tr   |                   | 20a. Method of Disposition   | wile  | 20b. F                    | Place of Dispos         | sition /Nam            | e of               | T                          | Da                       |                                 |   | tion - City or To   | The second secon |  |
| 9                          | Pages<br>nent of<br>int: If It<br>iny or o   |                   | 1 XBurial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)               | moval from St   | dile9                     | emetery, crem<br>craine |                        | ner piace          |                            | 7/21/                    | 2006                            | Wood  | lawn. M   | Maryland   |  |
| Baltimore,                 | 그런런를   |                   | 21. Signature of Funeral Service License   | 20//  | 2                         | 1 22                    | . Name and             | d Addres           | s of Facility              | Ster                     | ling A                          | shton   | Schwah  | Witzke   |  |
| Ô                          | Depe<br>Impo<br>eny l  |                   | Deman  | the   | weld                      | w 16                    | Funer<br>30 Ed         | al I               | lome o<br>Ison A           | of Ca<br>Venu            | tonsvi<br>e: Cat                | lle,<br>onsvi   | Inc.<br>11e, MI   | 21228  |  |
|                            |  |                   | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on | ations that cau   | ised the deat<br>th line. | h. Do not ente          | er the mode            | of dying           | , such as c                | ardiac or                | respiratory ar                  | rest,   |   | Approximate<br>Interval Between  |  |
|                            | Physician  |                   | tmmediate Cause (Final disease or condition                                      | meto.   | static                    | care                    | 1 non                  | a                  | 1 u                        | nce                      | stoin                           | priv  | nary  | Onset and Death  |  |
| ĺ                          | /Medical<br>Examiner   |                   | resulting in death)  | Due to (or  | as a conseq               | uence of):              |                        |                    | 7                          |                          |                                 |   | 1   |  |  |
|                            |  | -                 | Saquanitally flat conditions b   |   | as a conseq               | uence of):              |                        |                    |                            |                          |                                 |   | NAME OF THE OWNER OWNER OF THE OWNER |  |  |
| 2                          | uted<br>s<br>ansit   | Examiner          | Cause (Disease or injury   | ,   | ,                         |                         |                        |                    |                            |                          |                                 |   |   |  |  |
| Ď.                         | exection and and rial-tra  | Еха               | that initiated events resulting in death) Last                                   | Due to (or  | as a conseq               | uence of);              |                        |                    |                            |                          |                                 |   |   |  |  |
| 8760,d                     | cate be executed<br>physicien and<br>the burial-transit  | Physician/Medical | ٥  |   |                           |                         |                        |                    |                            |                          |                                 |   |   |  |  |
| 9                          | ertifica<br>ing pt   | Med               | IF FEMALE:   |   |                           |                         |                        |                    |                            |                          |                                 |   |   |  |  |
| Вох                        | ath ce   | lan/              | 23b. Was decedent pregnant in the past 12 months?                                |   | h 2 🗆 Feta                | f death 3               | Ectopic pre            |                    |                            |                          |                                 | 23d   | . Date of delive<br>Month   | ory<br>Day Year  |  |
| P.O.                       | The law requires thet the death certific<br>tie has been signed by the attending p<br>age 2 should be detached for use es:   | yslc              | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4∐Pregnar<br>9☐ Unknow  | nt at time of d           | eath 5                  | Other (spe             | ecify)             |                            |                          |                                 |   | 14101111  | Day Tour   |  |
|                            | thet the ed by detact  |                   | Part II. Other significant conditions con  | ributing to deal  | th but not res            | ulting in the un        | derlying ca            | use give           | n in Part I.               |                          | 23e. Did to                     | bacco use   | contribute to th  | ne cause of death?   |  |
| ds                         | uires<br>Sign  | Completed by      | Alcoholism.  | Hy per  | fens; E                   | in                      |                        |                    |                            |                          | 1 🗆 Y                           | es 2 🗆 N  | lo 3 ☐ Prob   | ably 4 Unknown   |  |
| <u>o</u>                   | w requir<br>s been si<br>should  | lete              | ,  | //  |                           |                         |                        |                    |                            |                          | 24a. Was a                      | an 2  | 4b. Were auto   | psy findings available   |  |
| æ                          | The lay<br>te has<br>age 2   | Eo                |  |   | <u> </u>                  |                         |                        |                    |                            |                          | autop                           | med?  | death?  | psy findings available inpletion of cause of   |  |
| ita                        | ician: Th<br>certificate<br>rector, pag  | Bec               | 25. Was case referred to medical   |   |                           |                         |                        |                    | 26. Place of               | of Death                 | 1 ☐ Yes<br>Check only           |   | 1   | ZLIENO   |  |
| <u>&gt;</u>                | Physician:<br>r this certifica<br>ral director, I  | 10                | examiner? 1 Yes 2 No   | ospital: 1 🗌 Inp  | atient 2                  | ER/Outpatient           | 3□ DO.                 | A Othe             | r: 4 🗆 Nurs                | sing Home                | e 5 4 Hesid                     | ence 6  | Other (Specify  | 1)   |  |
| ב<br>ס                     | ding P.<br>h.<br>After t   |                   | 27. Manner of Death 1 Naturaf 5 ☐ Pending  | 28a. Date of (Month,  | Injury<br>Day Year)       | 28b. Time of<br>Injury  | 28                     | Bc. Injury<br>Work | at<br>?                    | 28                       | 3d. Describe h                  | ow injury o   | ccurred   |  |  |
| sio                        | Attending or death.  ector: After by the fune  | cat               | 2 Accident investigation 3 Suicide 6 Could not be                                |   |                           |                         | М                      |                    | es 2 N                     |                          |                                 |   |   |  |  |
| Division of Vital Records, | or Attendation of after death Director:  | Certification:    | 4 Homicide determined  | building  | , etc. <i>(Specif</i> )   | ome, farm, stre<br>y)   | et, factory,           | office             |                            | 28                       | City or Tow                     | n, State)   | umber or Hura   | l Route Number,  |  |
| _                          | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page |                   | 29a. Certifier 1 Certifying Phys   | ician: To the b   | est of my kno             | wfedge, death           | occurred a             | it the time        | e, date and                | place, an                | id due to the c                 | ause(s) and   | d manner as st  | ated,  |  |
|                            | n 24 }<br>n 24 }<br>he Fu  | edical            | (Check only 2 Medical Examin   | er: On the bas<br>and manne   | is of examina             | tion and/or inv         | estigation,            | in my op           | inion, death               | occurred                 | d at the time, o                | ate and pla   | ice, and due to   | the cause(s)   |  |
|                            | To ti<br>To ti<br>Comp   | ž                 | 29b. Signature and title of certifier  |   | A                         |                         | 29c.                   | License            | number                     |                          | 2                               | 29d. Date s   | igned (Month, I   | Day, Year)   |  |
| }                          |  | l l               | ( (lan) les  | sur   | nos                       |                         | 8                      | >3                 | 263                        | 1                        |                                 | 7/  | 20/06   |  |  |
|                            | 15   |                   | 30. Name and address of person who cor   | ٠.  | of death (Item            |                         | Print)                 | 7.                 | 00 /                       | 2000                     | RI                              | (nd)  | 2/1.7/.   | 10)  |  |
|                            |  |                   | 31. Date filed (Month, Day, Year)  | in ser  | istrar's Signa            | tura                    | , ر                    |                    |                            | ryse                     | - al                            | UND   | Jour  | 51392  |  |
|                            | Sta<br>Registr   |                   | JUI 2.020  | 23  | estate a                  | K A                     | and!                   | )                  |                            |                          |                                 |   |   | 0100   |  |

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|  | /N   | led   |
|--|--|---|
| *  | Exa  | am  |
| A.   |  |   |
| Division of Vital Records, P.O. Box 68760, | el or Attending Physician: The law requires that the death certificate be executed | setter upairs. I also this certificate has been signed by the ettending physicien and in Directors. |
| Vita                                       | /sician:   | s certific  |
| Ö  | Ph)  | rth   |
| Division                                   | ei or Attending  | Director: After   |
| _  | 0,   | a =   |

| Physician /Medical Examiner   John W. Whitney, Jr.   Aa. Facility Name (If not institution, give street and number)   4b. City, Town, or Location of Death   ROSEDALE  | of Death th Day Year 7.36 AM 4c. County of Death BALTIMORE   |
|--|--|
| Medical Examiner   Soft W. Will they, ST.  | 4c. County of Death  |
| FUNERAL Director FUND SQUARE HOSPITAL ROSEDALE  FUND TRANSPORMENT OF THE PROPERTY OF THE PROPE |  |
| Funeral Director 5. Social Security Number 6. Sex 1 Months Days Hours Min. Sept. 57 Yrs. 6. Social Security Number 6. Sex 1 Months Days Hours Min. Sept. 6. Sex 1 Months Days Hours Min. Sex 1 Months Days Hours Min. Sex 1 Months Days Hours Min. Sex 1 Months Days Hours Min. Sex 1 Months Days Hours Min. Sex 1 Months Days Hours Min. Sex 1 Months Days Hours Min. Sex 1 Months Days Hours Min. Sex 1 Months Days Hours Min. Sex 1 Months Days Hours Min. Sex 1 Months Days Hours Min. Sex 1 Months Days Hours Min. Sex 1 Months Days Hours Min. Sex 1 Months Days Min. Sex 1 Months Days Min. Sex 1 Months Days Min. Sex 1 Months Days Min. Sex 1 Months Days Min. Sex 1 Months Days Min. Sex 1 Months Days Min. Sex 1 Months Days Min. Sex 1 Months Days Min. Sex 1 Months Days Min. Sex 1 Months Days Min. Sex 1 Months Days Min. Months Day | DALIMOU  |
|  | of Birth 9. Birthplace (State or Foreign Country) 19, 1948 Maryland  |
| Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  | 10d. Inside City Limits  |
| Maryland Baltimore    10a. State   | 1 ☐ Yes 2X☐ No   |
| To a. State   10b. County   10c. City, Town or Location   10d. Zip Code   10d. | 10g. Citizen of What Country?  |
| 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et  |  |
| 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1   |  |
| 3 XWidowed 4 Divorced Year or Dates:   | Specify: White   |
| 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 6th  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bailer   | 16b. Kind of Business/Industry   |
| Elementary/Secondary (0-12) College (1-4or 5+) 6th Bailer  | Box Company  |
| 第五号 を  |  |
| 15. Decedent's Education   16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   18. Mother's Name (First, Nother's Name   |  |
| 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)   | 20c. Location - City or Town, State  |
| 4 Donation 5 Other (Specify)  Bayview Crematory 7/15/2006  21. Signature of Funeral Service Licensee   |  |
| Gonce Specific Signature of Funeral Service Licensee 4001 Ritchie Highway B  | Funeral Service, P.A. altimore, Maryland 21225   |
| 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral shock, or heart failure. List only one cause on each line.  | tory arrest, Approximate Interval Between Onset and Death  |
| Physician /Medical   | ONE Mount  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):   | DATHY AND SKIN CHADNE MOUNTH   |
| but a see but a  |  |
| Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death and last resulting in the underlying cause given in Part I.  Cause (Disease or injury that initiated events resulting in death and last resulting in the underlying cause given in Part I.  Cause (Disease or injury that initiated events resulting in the underlying cause given in Part I.  Cause (Disease or injury that initiated events resulting in the underlying cause given in Part I.  Cause (Disease or injury that initiated events resulting in the underlying cause given in Part I.  Cause (Disease or injury that initiated events resulting in the underlying cause given in Part I.  Cause (Cause (Disease or injury that initiated events resulting in the underlying  | 23d. Date of delivery<br>Month Day Year  |
| Fart II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | Did tobacco use contribute to the cause of death?  |
| Fact ii. Other significant contributing to death but not resulting in the underlying cause given in Part I.  239.  40  | 1 Yes 2 No 3 Probably 4 Unknown  |
|  | Was an autopsy performed? Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No |
| 1 D 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 D  |  |
| E E 27 Manner of Death 28a Date of Injury 28b Time of 28c Injury at 28d Des  | Residence 6 Other (Specify) cribe how injury occurred  |
| The state of the s |  |
| 27. Magner of Dealt   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   Yes   2   No   28d. Description    | tion (Street and Number or Rural Route Number,<br>or Town, State)  |
| 29a. Certifier (Check only one)   29b. Signatural and title of certifier and manner stated.   29c. License number   29c. License n   | o the cause(s) and manner as stated.<br>time, date and place, and due to the cause(s)  |
| 29b. Signature and title of certifier 29c. License number  | 29d. Date signed (Month, Day, Year)  |
| 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | July 13, 2006  |
| 20 Now and address of several who completed source of death (how 20-) 77 00 11   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR LINDS AV HOELSCHER 9000 FRANKLIN SQUARE DR. P  State  11. Date filed (Month, Day, Year)  12. Ris strar's Signature  JUL 2 0 2006  | raltimore MD 21237   |

# 06-05068

# Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygien

| on Williams   |                |  | Pertificate of Death  | Reg. No. 2006 2277   |
|---|----------------|--|---|--|
| Physici<br>ledical Exami  | an/            | 1. Decedent's Name (First, Middle, Last)   |   | 2. Date of Death Month Day Year July 15, 2006  3. Time of Death 0200 hrs               |
|   |                | 4a. Facility Name (if not institution, give street and number)   | 4b. City, Town, or Location of De-<br>Baltimore   | ath 4c. County of Death  |
| Funeral   |                | Johns Hopkins  5. Social Security Number 6. Sex 7. Age (In y   | rs, last birthday) If Under 1 Year If Under 24  |  |
| Director  |                | 213 31 6799 13M 2_F 15   | O Yrs. Months Days Hours M  | SEPT. 27,19 Country) MD.   |
| any   |                | Usual Residence of Decedent  10a State 10b. County 10c. (  | City, Town or Location  | 10d Inside City Limits   |
| <b>.</b>  | ğ              | MD. N/A  | BALTIMORE   | 1X Yes 2 No  |
| , MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiers teath and Mental Hygiers are 1° is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once   | Director       | 10e. Street and Number 3210 E. LOMBARD ST.   | 10f. Zip Code 21224   | 10g. Citizen of What Country? USA  |
| eath with<br>items 2.   | Funeral        | 11. Marital Status 12. Was Decedent Ever   Armed Forces?   | If Yes, specify Cuban, Mexican, Pue   |  |
| after de<br>ral", or  | by Ft          | 3 Widowed 4 Divorced of Dates:   | 1 Yes 2 XNo specify:  | Specify: BLACK   |
| 72 hours 1 "natus 1 Exam  |                | 15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12)  College (1-4 or 5+)  | d) 16a. Decedent's Usual Occupation (Give kind of during most of working life DO NOT use in | of work done 16b. Kind of Business/Industry retired)                                   |
| 5-0036<br>Iled within 72<br>Hygiene.<br>Jother than 'the Medical  | Completed      | 10 TH 17. Father's Name (First, Middle, Last)  | STUDENT 18 Mother's Na  | HERITAGE HIGH ame (First, Middle, Maiden Surname)                                      |
| 21215-C<br>21215-C<br>Mental Hygi<br>marked oth<br>ic event, the  | Be             | DION O. WILLIAMS SR.   | TRACE   | EY JACKSON   |
| Baltimore, MD 21215-C<br>permit. Pages I and 2 should be filled I<br>Department of Feath and Mental Hygi<br>Important: If item 27 is marked oth<br>injury or other traumatic event, the   | ٩              | 19a Informant's Name/Relationship (Type, Print)  TRACEY JACKSON(mother)  | - `   | or Rural Route Number, City or Town, State, Zip Code) ST. BALTO, MD. 21224             |
| re, M<br>: 1 and 2<br>F Health<br>f item 2  |                |  | 20b. Place of Disposition (Name of cemetery,  | Date 20c Location - City or Town, State  |
| Baltimore,<br>permit. Pages I an<br>Department of Hea<br>Important: If ite  |                | 4 Donation 5 Other Specify:  | ARBUTUS MEM.PK  | JLY 21,2006<br>BALTO,MD.   |
| Balt permit. Depart Import  |                | Memadine 7. Arrive   | MINIO E DEECTOR   | GGS FUNERAL HOME   |
| Physician<br>/Medical   |                | 23a. Part I. Enter the disease, or complications that caused the gradure. List only one cause on each line.  |   | c or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death  |
| ≒xaminer  |                | Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot W. Due to (or as a consequent)  |   |  |
|   | ī.             | Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequent | ice of):  |  |
| 1   | Examin         | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent of the conseque | ice of):  |  |
| executed an and al - transit  |                | d d AMENDED  |   |  |
| 60,<br>ate be en<br>ohysician<br>ne burial  |                | IF FEMALE: 23c. If yes, outcome of   | pregnancy   | 23d. Date of delivery  |
| Box 687<br>e death certific<br>the attending p  | ician/         | 23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at time   | 2 Fetal death 3 Ectopic predof death 5 Other (Specify)                                      | gnancy Month Day Year  |
| D. Box 68760, the death certificate be executed by the attending physician and ached for use as the burial - transit  | Physic         | 1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but it   | not resulting in the underlying cause given in Part I.                                      | 23e. Did tobacco use contribute to the cause of death?                                 |
| , P.O. rres that the signed by  | ģ              |  |   | 1 Yes 2 No 3 Probably 4 Unknown  |
| ords,<br>aw requir<br>as been s<br>2 should   | Completed      |  |   | 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? |
| :al Records itan: The law requi certificate has been  |                | 25. Was case referred to medical   | 26 Place of Death (Che  | 1 ✓ Yes 2 No 1 ✓ Yes 2 No  |
| n of Vital I<br>Jing Physician:<br>After this certifi<br>funeral director.  | To Be          | examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2   | 2 ✓ ER/Outpatient 3 DOA Other Nu  | rsing Home 5 Residence 6 Other:  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death or the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, after this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built |                | 27. Manner of Death  1 Natural 5 Pending  28a Date of Injury (Month, Day Year)  Jul 15, 2006   | 28b. Time of Injury 28c. Injury at Work?  0138 hrs 1 Yes 2 No                               | 28d. Describe how injury occurred Subject shot   |
| IVISION or Attendather death Director:  | Certification: | 3 Suicide Could not be   | At home, farm, street, factory, office building, etc.                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)           |
| Divis  Lospital or A 4 hours after "uneral Dire   |                | 4 Homicide determined (Specify) Street  29a. Certifier (Check only) 1 Certifying Physician: To the best of my kno  | wledge, death occurred at the time, date and place, a                                       | 2727 East Monument Street, Baltimore, MD and due to the cause(s) and manner as started |
| Di To the Hospital within 24 hours a To the Funeral I completely filled   | Medical        | one) 2 Medical Examiner: On the basis of examinat and manner stated  | ion and/or investigation, in my opinion, death occurre                                      | ed at the time, date and place, and due to the cause(s)                                |
|   | 2              | 29b. Signature and title of certifier  | O.C.M.E.  | 29d. Date signed (Month, Day, Year)  July 15, 2006                                     |
| 3   |                | 30 Name and address of person who completed cause of death   |   | 2000 MD 21201  |
|   | tate           | Patricia Aronica-Pollak MD. Assistant Media 31. Date filed (Month, Day, Year)  32. Registrar's Signary   | gnature   | IOIE, MID 21201  |
| Real  |                | 1111 - 0 2000  | M. Boach D  |  |

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 4a. Facility Name (If not institution, give street and number) WALLACE /Medical 18 2006 4b. City, Town, or Location of Death Examiner 4c. County of Death 1712 N. SMALLWOOD ST. BALTIMORE N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 21 F Yrs. Director 240-34-1571 9-11-1913 NORTH CAROLINA Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location r then "natural", or items 23s or 28s-f ehow the Medical Experiment was be notified at 10d. Inside City Limits MD. N/A BALTIMORE 1 Tyres 2 □ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v 1712 N. SMALLWOOD ST. 21216 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours atter c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iten eny injury or other traumatic event, the Medical Exprintmenance. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: þ Specify: BLACK 3.☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -6--0-PRIVATE DUTY NURSE HEALTHCARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILL MCPHATTER ROSETTA McKENZIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARSHALL BARNES (GRANDSON) 1712 N. SMALLWOOD ST. BALTIMORE, MARYLAND 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Ofemation 3 Removal from State DOUBLE (Specify)ENTOMBMENT DRUID RIDGE CEMETERY 7-19-2006 4 Donation BALTIMORE, MARYLAND JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. Yus. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1. Of ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician METASTATI'C MELANOMA disease or condition resulting in death) MONNIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit the attending physician and the for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 MRAGRAMIAL HP. MORMAGES Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 🗆 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of Injury After 28d. Describe how injury occurred 1 Naturat 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after c Funeral Direct 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) EDAHUS M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) · BAGINONE MS 21201 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State JUL 2 0 2006 Registrar DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

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|                |  |                  | = Stata<br>Registrar  |                                   | Ce                                      | rtificate of                              | f Death                                       | Re  | g. No.                                       | 66100   |
|----------------|--|------------------|---|-----------------------------------|---|---|---|---|--|---|
|                |  |                  | Decedent's Name (First, Middle, Last                                    | n)                                |   |   |   | 2. Date of Death                              |  | 3. Time of Death                                |
|                | Physicia   |                  | Howard  | 1enninas                          | Anthony                                 |   |   | JULV/   | T 2006                                       | 1740 M  |
|                | /Medic<br>Examin   |                  | 4a. Facility Name (If not institution, give                             |                                   | 72,2-2,7-2,7-2,9                        |   | or Location of Death                          |   | 4c. County of Deat                           |   |
|                | LXamiii  | -1               | THE MEMORI  | n Hos                             | SPITAL                                  |   | ASTON   |   | TALI   | ROT   |
|                | Funeral  |                  | 5. Social Security Number 6. Se   | -/-                               | e (In yrs. last birthday                |   |   | 8. Date of Birth                              |  |   |
|                | Funeral<br>Director  |                  | 212-12-0696   | ZM 2□F                            | 85 Yrs.                                 | Months Day                                | s Hours Min.                                  | 8. Date of Birth<br>(Month, Day,<br>September | Year) Co                                     | hplace (State or Foreigr<br>untry)<br>NSYLXINIC |
|                |  |                  | Usual Residence of Decedent   |                                   | 07                                      |   |   | september                                     | 13,1720 120                                  | rogenina  |
|                | land   |                  | 10a. State 10b. County  |                                   | 10c. City, Town or L                    | ocation                                   |   |   |  | 10d. Inside City Limits                         |
|                | Mary   | ō                | Maryland Caro   | line                              | Greens                                  | boro                                      |   |   |  | 1 ☐ Yes 2 ☐ No                                  |
|                | 28a  | ec               | 10e. Street and Number  |                                   |   | 10f. Zip Code                             |   | 10  | g. Citizen of What Co                        | untry?  |
|                | with   | ₫                | 11842 Kibler R  | oad                               |   | 2163                                      |   |   |  | •   |
|                | be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "naturel", or Items 23a or 28a-f ehow event, the Medical Examinat must be notified at   | Funeral Director | 11. Marital Status  | 12. Was Decedent I                | Ever in II S 13                         | Was Decedent of                           | Hispanic Origin? (Sp                          |   | ited States                                  | ,   |
|                | Per d  | Š                | 1 Never Married 2 Married   | Armed Forces? 1 ☐ Yes 2 ☑ N       |   | If Yes, specify Cu                        | ban, Mexican, Puerto                          | Rican, etc.)                                  | Black, White                                 |   |
| 36             | rs aff   |                  | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:    | 40                                      | 1 ☐ Yes 2√2 N                             | o Specify:                                    |   | Specify:                                     |   |
| 21215-0036     | hou ture   | Completed by     | 15. Decedent's Edi  |                                   | 163 Door                                | edent's Usual Occ                         | unation                                       | 4.  |  | casian  |
| 5              | n 72   | let              | (Specify only highest grad  |                                   | (Giv                                    | e kind of work don<br>DO NOT use retir    | e during most of work                         | king "  | 6b. Kind of Business/                        | industry  |
| 12             | within one.  ene.  then "then then "then "then "then "then "then "then "then "then "then " | Ę                | Elementary/Secondary (0-12)   | College (1-4or 5                  | i+)                                     |   | <i>'</i>                                      |   | 2      |   |
| 7              | filed with<br>Hygiene<br>Ither the   |                  | 17. Father's Name (First, Middle, Last)                                 |                                   | 1 1/2                                   | uck Driver                                |   | e (First, Middle, M                           | County Roads                                 |   |
| Maryland       | should be filed<br>nd Mental Hygi<br>marked other<br>matic event,  | Be               |   |                                   | , ,                                     |   |   |   | alderi Surramej                              |   |
| ž              | should<br>nd Men<br>marke  | ٩                | Howard Lei  |                                   |   |   |   | e Turner                                      |  |   |
| a              | 2 2 2  | 12               | 19a. Informant's Name/Relationship (T                                   |                                   |   | -   |   |   | City or Town, State, Z                       |   |
|                | and 2<br>ealth<br>m 27 i   |                  | Edith Ann Corkell   | . Dau                             | -                                       |   |   |   | aryland 21                                   |   |
| ore            |  |                  | 20a. Method of Disposition  1   | Removal from State                | 20b. Place of Disp<br>cemetery, cre     | osition (Name of<br>ematory or other pi   |   | Date 2  | 0c. Location - City or                       | Town, State                                     |
| Ĕ              | Pages<br>Iment of h<br>lant: If Its  |                  | 4 □ Donation 5 □ Other (Specify,  |                                   | Green mou                               | rt Ceme                                   | tery 7/12                                     | 12006 H                                       | Hillsboro,                                   | Maryland  |
| Baltimore,     | permit. Page<br>Department of<br>Important: If<br>eny Injury or<br>ance.   |                  | 21. Signature of Funeral Service Licens                                 | hore                              |   |   | ress of Facility<br>Uneral Hor                |   |  |   |
|                |  |                  | 23a. Part 1. Enter the disease, or comp                                 | lications that caused             | the death. Do not er                    | 12 South                                  | Second S                                      | treet, Dei                                    | rton, Mary                                   | and 21629 Approximate                           |
|                |  |                  | shock, or heart failure. List only of                                   | ne cause on each lir              | ne.                                     | _   |   | or respiratory arres                          | st,  | Interval Between<br>Onset and Death             |
|                | Physician  |                  | Immediate Cause (Final disease or condition resulting in death)         | · Conge                           | a consequence of):                      | and the                                   | ilure   |   |  | days  |
|                | /Medical<br>Examiner   |                  | resulting in death)   | Due to (or as                     | a consequence of):                      | Į.  |   |   |  | 0   |
|                | Lxammer  |                  | Sequentially list conditions,   | b                                 |   |   |   |   |  |   |
|                | D #  | Iner             | d any, leading to immediate cause. Enter Underlying                     | Due to (or as                     | a consequence of).                      |   |   |   |  |   |
|                | icate be executed<br>physicien and<br>s the burial-transit   | Examin           | Cause (Disease or injury that initiated events resulting in death) Last | c                                 |   |   |   |   |  |   |
| oʻ             | e exe<br>ien a<br>uriad-   |                  | resulting in death) cast  | Due to (or as                     | a consequence of):                      |   |   |   | 1  |   |
| 68760,         | ate b<br>nysic<br>he bi  | Ca               |   | d                                 |   |   |   |   |  |   |
|                | Jeath certificate be executed<br>i attending physicien and<br>I for use as the buriat-transit  | /Medical         | IF FEMALE:  |                                   |   |   |   |   |  |   |
| Вох            |  |                  | 23b. Was decedent pregnant  | 23c. If yes, outcome              |   | □Ectopic pregnan                          | CV  |   | 23d. Date of deli                            |   |
|                | 0 0 0  | 200              | in the past 12 months?  | 4☐Pregnant at<br>9☐Unknown        |   | Other (specify)                           | -,  |   | Month  | Day Year  |
| P.0            | at the de<br>by the a  | Physician        | 9 🗆 Unknown   | 9LI UNKNOWN                       |   |   |   |   |  |   |
|                | es that<br>igned b   | БуР              | Part II. Other significant conditions co                                | ntributing to death be            | ut not resulting in the                 | underlying cause g                        | iven in Part I.                               | 23e. Did toba                                 | cco use contribute to                        | the cause of death?                             |
| Ĕ              | quire<br>or sig  |                  | pericudit   |                                   | 14 perta                                | sion                                      |   | 1 ☑ Yes                                       | 2 □ No 3 □ Pro                               | bably 4 Unknown                                 |
| ္ပ             | w requir   | et               | revel Frile   | ٠ .                               | / '                                     |   |   | 24a. Was an                                   | 24b. Were aut                                | topsy findings available                        |
| Vital Records, | The law requires that the sete hes been signed by the page 2 should be detache   | Completed        | C. Da Q - C.  | 6 1/1                             |   |   |   | autopsy<br>performe                           | prior to c<br>death?                         | ompletion of cause of                           |
| ē              | iclan: The   | Ö                | 25. Was case referred to medical  | my                                | -                                       |   |   |   |  | 2□ No   |
| ₹              | Physician:<br>this certificant   | 0                | examiner?   | Hospital:                         |   | 0   | ther  | h Check only one                              |  |   |
| οţ             | Phy<br>rald  | 5                | 1 ☐ Yes 2 ☑ No<br>27. Manner of Death                                   | 1 Inpatie                         |   | INT 3 DOA                                 | 4 LI Nursing Ho                               | ome 5 ☐ Residen<br>28d. Describe how          | ce 6 Other (Spec                             | ufy)  |
| S              | ding P.<br>h.<br>After<br>funera   | <u></u>          | 1 ☑Natural 5 ☐ Pending  | 28a. Date of Injui<br>(Month, Day | Year) Injury                            | W   | ork?  | 200. Describe now                             | riquiy occurred                              |   |
| S.             | Attending<br>r death.<br>ector: After<br>by the fune   | cat              | 2 Accident investigation 3 Suicide 6 Could not be                       | 20a Blace of Init                 |   |   | ]Yes 2 □No                                    | 001 1   |  |   |
| Division       | 2 8 2 2  | Certification:   | 4 ☐ Homicide determined   | building, etc                     | ury - At home, farm, si<br>c. (Specify) | reet, ractory, office                     | •   | City or Town,                                 | et and Number or Ru<br>State)                | rai Houte Number,                               |
| U              | t hours a unerel E   |                  |   | 1                                 |   |   |   |   |  |   |
|                | o the Hospital of thin 24 hours aft of the Funeral Dompletely filled in  | Medical          | (Check only 2 Medical Exam  | inar: On the basis of             | examination and/or in                   | th occurred at the<br>rvestigation, in my | time, date and place,<br>opinion, death occur | and due to the cau<br>red at the time, dat    | ise(s) and manner as<br>e and place, and due | stated.<br>to the cause(s)                      |
|                | the<br>the<br>in 2   | Ned              | 29b. Signature and title of certifier                                   | and manner sta                    | ued.                                    |   | nse number                                    |   | d. Date signed (Month                        |   |

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

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|---|------------------|--|---|---|-----------------|-----------------------------------|-------------------------------|----------------------|--|--------------------------------------|---|---------------------------------|--|--|
|   | -                | For State  | D//22 5: 1                                      | State of Ma   | -               |                                   |                               |                      |  | vientai H                            | ygiene<br>Reg. No.  |                                 | 22781  |  |
|   |                  | 1. Decedent's Name   | D#23a-Pt-1,                                     | 24bperMD7/  | 6/06 <b>,</b> I | MW.MH95                           | incate                        | OIL                  | Jean                                     | 2. Date of D                         |   | _ 0 0 0                         | 3. Time of Death                                   |  |
| Physicia  |                  |  |   | DOLPH BE  | ROWN,           | SR.                               |                               |                      |  | JUNE                                 | 29 <sup>Day</sup>   | 2006 Year                       | 10:05 P.M  |  |
| /Medica<br>Examine  |                  | 4a. Facility Name (If  |   |   |                 |                                   | 4b. City, To                  | own, or              | Location of Death                        |                                      |   | County of Deat                  |  |  |
|   |                  | VA MARYLA  | AND HEALTH                                      | CARE SY   | STEM            |                                   |                               | PE                   | RRY POIN                                 | f r                                  | CECIL   |                                 |  |  |
| Funeral   |                  | 5. Social Security Nu  | . 75  | 7. Ag   |                 | last birthday)                    | If Under 1<br>Months          | Year<br>Days         | If Under 24 Hrs.<br>Hours Min.           | (Month, I                            | av. Year)   | 9. Birti<br>Co                  | hplace (State or Foreign                           |  |
| Director  | -                | 223-36-5 Usual Residence of I  | 911   | W 201   | 75              | Yrs.                              |                               |                      |  | Apr.                                 | 19, 1   | 931 Vir                         | ginia  |  |
| ow ow   |                  |  | 10b. County                                     |   | 10c. Cit        | y, Town or Lo                     | cation                        |                      |  | - MIT                                |   | 10d. Inside City Limits         |  |  |
| Man,  | to               | Virginia   | None  |   | Ма              | nassas                            |                               |                      |  |                                      |   |                                 | P∰¥es 2 ☐ No                                       |  |
| th the<br>or 28¢  | Director         | 10e. Street and Num  | ber   |   |                 | 10f. Zip C                        | Code                          |                      |  | 10g. Citi                            | zen of What Co  | untry?                          |  |  |
| rs after death with the Marylan<br>I, or items 23a or 28a-f show<br>Marrings must be rollified at   | rai              | 10318 Po   | e Drive   |   |                 |                                   |                               | 110                  |  |                                      | U.S   | .A.                             |  |  |
| er deg  | Funeral          | 11. Marital Status   |   | 2. Was Decedent Armed Forces?                                 |                 | S. 13. \                          | Vas Decede<br>f Yes, specif   | nt of Hi<br>fy Cuba  | ispanic Origin? (Si<br>n, Mexican, Puert | pecify Yes or No Rican, etc.)        | offy Yes or No-<br>Rican, etc.) 14. Race - American I<br>Black, White, etc. |                                 |  |  |
| rs aft  | by F             | 1 Never Marrie   |   | 1 <b>XX</b> Yes 2 ☐ N<br>If Yes, Give<br>Year or Dates: ]     |                 | .105%                             | I⊡Yes 20                      | MNo                  | Specify:                                 |                                      |   | Specify:                        | 1-   |  |
| filed within 72 hours after death with the Maryland<br>Hygiene.<br>kther than "natural", or items 23a or 28a-f show<br>ant, the Medical Examinar must be nutified at  |                  |  | 15. Decedent's Educ                             | ation   | 1901-           | 16a. Deced                        | lent's Usual                  | Occupa               | ation                                    |                                      | 16b. Ki   | nd of Business/                 | ack<br>Industry                                    |  |
| thin 7.<br>an "n<br>Mad   | ple              | (Specification (Speci | fy only highest grade<br>ndary (0-12)           | College (1-4or 5  | i+)             | (Give<br>life. L                  | kind of work<br>DO NOT use    | done o<br>retired    | during most of wor<br>()                 | rking                                |   |                                 |  |  |
| ed wil  | Completed        | 11   |   |   | ·               | Sec                               | urity                         | Gua                  |  |                                      | U.S. Government   |                                 |  |  |
| be fill<br>htal H<br>od ott   | Be               | 17. Father's Name (F   | •   |   |                 |                                   |                               |                      | 18. Mother's Nan                         |                                      |   | Sumame)                         |  |  |
| should<br>and Men<br>marke  | ၉                |  | Daniel Br                                       |   |                 | 10h Mailin                        | a Address /                   | Stroot :             | Geneva                                   |                                      | th nber, City or Town, State, Zip Code)                                     |                                 |  |  |
| and 2 s<br>selth an<br>n 27 is i  |                  |  | own, Wife                                       | 56, 1 1111/   |                 |                                   |                               |                      |  |                                      |   | 0110                            | ap code)   |  |
| s 1 ar<br>f Hee<br>itsm<br>other  |                  | Alice Brown, Wife  10318 Poe Drive, Manassas, VA 20110  20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of Commetter). Crematory or other place)  Quantito   |   |   |                 |                                   |                               |                      |  |                                      |   |                                 | Town, State  |  |
| Pages<br>nent of<br>ant: if it<br>ant or o  |                  |  | ☐Cremation 3 ☐R<br>5 ☐ Other (Specify)          | emoval from State   | Qu              | antico<br>ationa                  | 1 Ceme                        | eter                 | v Jul.                                   | 7,200                                | Tri   | angle,                          | VA   |  |
| pernit. Pages 1 and 2 should be filed within 72 hours<br>Depertment of Heelth and Mental Hyglene.<br>Important: if itsm 27 is marked other than "natural;<br>any injury or other treumatic event, the Medical Ex<br>once. |                  | 21. Signature of Fun   | neral Service License                           | 98  |                 |                                   |                               |                      | ss of Facility AM                        |                                      |   |                                 |  |  |
| 0 99 = 99   |                  | Jan  | ack City  | round   |                 |                                   |                               |                      | ry Road,                                 |                                      |   | VA 201                          | 10   |  |
|   |                  | shock, or hear   | e disease, or compli<br>t failure. List only or | cations that caused<br>e cause on each lin                    | the deat        | h. Do not ent<br>r Tachi          | er the mode                   | of dyin              | g, such as cardiac                       | or respiratory                       | arrest,   |                                 | Approximate<br>Interval Between<br>Onset and Death |  |
| Physician   |                  | shock, or heart failure. List only one cause on each line. Lar Tachicardia Immediate Cause (Final disease or condition resulting in death)  Tachicardia RESPIRATORY FAILURE  a. — RESPIRATORY FAILURE  |   |   |                 |                                   |                               |                      |  |                                      |   |                                 | UNKNOWN  |  |
| /Medical<br>Examiner  |                  | rooting in county  | (   | Due to (or as   |                 |                                   |                               |                      |  |                                      |   |                                 |  |  |
|   | er               | Sequentially list con<br>it any, leading to im-<br>cause. Enter Under<br>Cause (Disease or in  | nditions, b                                     | Aspira Due to (or as  |                 |                                   | onia                          |                      |  |                                      |   |                                 | Unknown  |  |
| uted<br>d<br>ansit  | Examiner         | Cause (Disease or in<br>that initiated events  | rlying<br>njury                                 | cular A   | Accide          | nt                                |                               |                      |  |                                      | Unknown   |                                 |  |  |
| be executed<br>ician and<br>burial-transit  | EX               | resulting in death) L  | ast   | Due to (or as   | a conseq        | uence of):                        |                               |                      |  | ·                                    |   |                                 |  |  |
| م دی س  | lca              |  |   |   |                 |                                   |                               |                      |  |                                      |   |                                 |  |  |
| eath certifica<br>attending pl  | /Me              | IF FEMALE: 23c, If yes, outcome of pregnancy   |   |   |                 |                                   |                               |                      |  |                                      |   |                                 |  |  |
| atten<br>I for u  | Physiclan/Medica | in the past 12 r   | months?   | 1 ☐ Live birth<br>4 ☐ Pregnant at                             | 2 Feta          | Ideath 3□                         | Ectopic pred                  |                      |  |                                      |   | 23d. Date of deli<br>Month      | Day Year   |  |
| at the de<br>by the a<br>tached   | hysi             | 1 ☐ Yes 2 ☐<br>9 ☐ Unknown   | INO   | 9□ Unknown  |                 |                                   |                               |                      |  |                                      |   |                                 |  |  |
|   | by P             | Part II. Other signifi   | cant conditions cor                             | tributing to death b  | ut not res      | ulting in the u                   | nderlying cau                 | use give             | en in Part I.                            | 23e. Did                             | tobacco u   | se contribute to                | the cause of death?                                |  |
| w require<br>been sig<br>should b   | ted              |  |   |   |                 |                                   |                               |                      |  | 1 [                                  | ]Yes 2[   | □No 3□Pro                       | obably 4 XUnknown                                  |  |
| e law r<br>has be   | Completed        |  |   |   |                 |                                   |                               |                      |  | 24a. Wa<br>aut                       | s an<br>opsy  | prior to d                      | topsy findings available<br>completion of cause of |  |
|   | Con              |  |   |   |                 |                                   |                               |                      |  |                                      | formed?<br>2 \( \subseteq \text{No}   | death?                          | 2[ <b>X</b> No                                     |  |
| ysician: Th<br>is certificate<br>director, pag  | o Be             | 25. Was case referrence examiner?  | 1   | ospital: , x,   |                 |                                   |                               | Othe                 | 26. Place of Dea                         |                                      |   |                                 |  |  |
| Physic ruthis aral di   | -                | 27. Manner of Death  |   | 28a. Date of Inju<br>(Month, Da                               |                 | ER/Outpatien<br>28b. Time of      |                               | c. Injun             | / at                                     | lome 5 ☐ Re:<br>28d. Describe        |   | 5 ☐Other (Spec<br>y occurred    | cify)  |  |
| nding<br>ath.<br>r: Afte<br>e fun   | atloi            | 1XXNatural<br>2 ☐ Accident   | 5 Pending investigation                         | (Month, Da  | y rear)         | Injury                            | м                             | Worl                 | k?<br>Yes 2 □ No                         |                                      |   |                                 |  |  |
| r Atte<br>er de<br>recto<br>by th   | Certification:   | 3 Suicide<br>4 Homicide  | 6 Could not be determined                       | 28e. Place of Inj<br>building, et                             | ury - At h      | ome, farm, str                    | eet, factory,                 | office               |  | 28f. Location<br>City or T           | (Street and   | d Number or Ru                  | ral Route Number,                                  |  |
| itel o<br>irs aft<br>rei Di   | Cer              |  |   |   |                 |                                   |                               |                      |  | ly in                                |   |                                 |  |  |
| To the Hospitel or Attending Physicien:<br>within 24 hours after death.<br>To the Funerel Director: After this certific<br>completely filled in by the funeral director.  | edical           | 29a. Certifier<br>(Check only<br>one)  | 1 X Certifying Phys<br>2 Medicel Exemi          | sician: To the best<br>ner: On the basis of<br>and manner sta | f examina       | wledge, death<br>ition and/or inv | occurred at<br>vestigation, i | t the tim<br>in my o | ne, date and place<br>pinion, death occu | , and due to the<br>rred at the time | e cause(s)<br>e, date and   | and manner as<br>place, and due | stated.<br>to the cause(s)                         |  |
| o the<br>ithin 2<br>o the<br>omple  | Med              | 29b. Signature and   | title of certifier                              | and manner ste  | 7               |                                   | 29c.                          | License              | e number                                 |                                      | 29d. Dat  | e signed (Month                 | n, Day, Year)                                      |  |
| 1 5 5   |                  | V R  | whan  | m V   | SA              | Be 1                              | 2                             |                      | D40723                                   |                                      | JUNE  | 29, 20                          | 006  |  |
| 1->   |                  | 30. Name and addre   | ess of person who co                            | mpleted cause of d  | leath (Iten     | n 23a) (Type,                     | Print)                        |                      |  |                                      |   |                                 |  |  |
|   |                  |  | OM ISAAC,                                       |   |                 |                                   |                               |                      | RE SYSTE                                 | M, PERR                              | Y POI   | NT, MD                          | 21902  |  |
| Sta<br>Registr  |                  | 31. Date filed (Mont   | JUL 06 2  | 32. Begistr   | ars Signa       | B. A                              | mile                          |                      |  |                                      |   |                                 |  |  |

|                |  |                | For State Registrar   | State                 | of Ma                               | •                                 | •                         | tment of He<br>ificate of D               |                                 | d Mental H                                 | ygien<br>Reg. N          | 21111                                   | 6 22  | 782                |
|----------------|--|----------------|---|-----------------------|-------------------------------------|-----------------------------------|---------------------------|---|---------------------------------|--|--------------------------|---|---|--------------------|
|                | Disconini  |                | 1. Decedent's Name (First, Middle, L  | ast)                  |                                     |                                   |                           |   |                                 | 2. Date of<br>Month                        | Death<br>Da              | ay Yea                                  | 3. Time of  | Death              |
|                | Physici<br>/Medic  |                | LEO E. BALK   |                       |                                     |                                   |                           |   |                                 | JULY                                       | 01                       |   | 77.   | :30 PM             |
| )              | Examin   | _              | 4a. Facility Name (If not institution, g  | ive street and n      | u <i>mber)</i>                      |                                   |                           | 4b. City, Town, or                        | Location of D                   | eath                                       | 44                       | c. County of De                         | ath   |                    |
|                |  |                | 2409 HAYDEN DRIVE   |                       |                                     |                                   |                           |   | SPRING                          | Hea I a a                                  |                          | ONTGOMER                                |   |                    |
|                | Funeral  |                | ,   | Sex<br>1⊠M 2□F        | 7. Age                              | (In yrs. last birth               |                           | If Under 1 Year<br>Months Days            | Hours N                         | Ain. (Month,                               | Day, Year                | 7)                                      | lirthplace (State of Country)                                       | or Foreign         |
|                | Director   |                | 468-80-8118 Usual Residence of Decedent   | ••                    |                                     | 79                                |                           |   |                                 | DECEMB                                     | SR 18,                   | 1926                                    | RUSSIA  |                    |
|                | /land  |                | 10a. State 10b. County  |                       |                                     | 10c. City, Town                   | or Loca                   | ation                                     |                                 |  |                          |   | 10d. Inside C   | City Limits        |
|                | Man  | tor            | MARYLAND MONTGOME   | RY                    |                                     | SILV                              | ER S                      | PRING                                     |                                 |  |                          |   | 1 🗆 Yes   | 2 <b>∑</b> No      |
|                | h the  | Director       | 10e. Street and Number  |                       |                                     |                                   |                           | 10f. Zip Code                             |                                 |  | 10g. C                   | itizen of What                          | Country?  |                    |
|                | deeth with the Maryland<br>ime 23a or 28a-f ehow<br>rivert be notified at  |                | 2409 HAYDEN DRIVE   |                       |                                     |                                   |                           | 2090                                      | 2                               |  |                          | U.S.A                                   | •   |                    |
|                | eep L  | Funerai        | 11, Marital Status  | 12. Was De<br>Armed I | orces?                              |                                   | 13. W                     | as Decedent of His<br>Yes, specify Cubar  | panic Origin                    | (Specify Yes or uerto Rican, etc.)         | No-                      | 14. Race - Al<br>Black, W               | merican Indian,   |                    |
| 2              | or It  | by Fu          | 1 Never Married 2 Married   | If Yes, C             |                                     | 0                                 |                           | JYes 2⊠No                                 | Specify:                        |  |                          | Specify:                                |   |                    |
| 3-003e         | within 72 hours after<br>ene.<br>then "naturel", or Ite  |                | 3 Widowed 4 Divorced  | Year or               | Dates:                              | 160 0                             | lacada                    | nt's Usual Occupa                         | N                               |  | 105                      |   | WHITE   |                    |
| Ċ              | n 72   | jete           | 15. Decedent's<br>(Specify only highest g   | rade completed        |                                     |                                   | Give ki                   | ind of work done di<br>O NOT use retired) |                                 | working                                    | 160.                     | Kind of Busine                          | ss/industry   |                    |
| 7              | withi<br>iene.<br>ther   | Completed      | Elementary/Secondary (0-12)   | College<br>5-         | (1-4or 5+                           | -)                                |                           | EDITOR                                    |                                 |  | VO                       | ICE OF A                                | MERICA  |                    |
| <u> </u>       | Hygi<br>other  | 80             | 17. Father's Name (First, Middle, La  |                       |                                     |                                   |                           |   | 18. Mother's                    | Name (First, Mide                          | ile, Maide               | n Sumame)                               | ·   |                    |
| /land          | 2 should be and Mental le marked c   | To B           | EDWARD BALK   |                       |                                     |                                   |                           |   | EDITH                           | 1 DEXTER                                   |                          |   |   |                    |
| _              | should<br>and Men<br>marke<br>umatic   | _              | 19a. Informant's Name/Relationship  | (Type, Print)         |                                     | 19b. I                            | Mailing                   | Address (Street a                         | nd Number o                     | r Rural Route Nui                          | nber, City               | or Town, State                          | , Zip Code)   |                    |
| , Mai          | 1 end 2<br>Heelth a<br>tem 27 le   |                | JOSEPHINE BALK - WI   | FE                    |                                     | 24                                | 09 H                      | AYDEN DRIV                                | E, SILVE                        | ER SPRING,                                 | MARYL                    | AND 2090                                | 2   |                    |
| 9              | Tite The   | 3              | 20a. Method of Disposition<br>1 ☐ Burial 2 🖾 Cremation 3  | □ Removal from        | n State                             | 20b. Place of Cometery,           | Disposi<br>, <i>crema</i> | tion (Name of<br>atory or other place     | )                               | Date                                       | 20c. I                   | Location - City                         | or Town, State  |                    |
| Ĕ              | nit. Peges 1 end 2 should be filed within 72 hours after deeth with the Marylan entiment of Heelth and Menial Hygiene. ortant: If Item 27 ie marked other then "naturel", or Iteme 23a or 28a-f show injury or other traumatic event, the Medical Examination in the notified at a second of the contraction of the contracti |                | 4 □ Donation 5 □ Other (Spec  |                       |                                     | FORT LIN                          | COLN                      | CREMATORY                                 | JUI                             | Y 6, 2006                                  | BRE                      | NTWOOD,                                 | MARYLAND  |                    |
| Baitimore,     | permit. Pege<br>Depertment<br>Important: If<br>eny injury or<br>once.  |                | 21. Signature of Funeral Service Lice  Muselin T.   | onsoo<br>Vlbbert      | _                                   |                                   |                           | Name and Address OO NEW HAM               |                                 | HINES-RINA                                 | LDI F                    | UNERAL H                                | OME, INC  | 1904               |
| ,              | Fnysician<br>/Medical<br>Examiner  | <u>.</u>       | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of): |                       |                                     |                                   |                           |   |                                 |  |                          |   | Approxima<br>Interval Bei<br>Onset and                              | tween<br>Death     |
| 8/60,          | cate be executed<br>physicien end<br>the burial-transit  | al Examiner    | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events<br>resulting in death) Last  | cDue to               | Due to (or as a consequence of):    |                                   |                           |   |                                 |  |                          |   |   |                    |
| 28             |  | edical         |   | d                     |                                     |                                   |                           |   |                                 |  |                          |   |   |                    |
| C. BOX         | at the death certifi<br>by the attending I<br>tached for use as  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)   |                       |                                     |                                   |                           |   |                                 |  | -                        | 23d. Date of delivery<br>Month Day Year |   |                    |
| rds, P         | quires that<br>n signed b<br>uld be deta   | þ              | Part II. Other significant conditions   | contributing to       | death bu                            | t not resulting in t              | the und                   | derlying cause give                       | n in Part I.                    |  |                          | co use coninbute to the cause of death? |   |                    |
| Vital Hecords, | . The law requires that sete has been signed b page 2 should be deta   | Completed      |   |                       |                                     |                                   |                           |   |                                 | 24a. W<br>au<br>pe<br>1 🗆 Ye               | topsy<br>rformed?        | prior death                             | autopsy findings<br>to completion of a<br>?<br>es 2 \( \square\$ No | available cause of |
| /ita           | iclan: Th<br>certificete<br>rector, pag  | Be             | 25. Was case referred to medical examiner?  | 110 - 2 -             |                                     |                                   |                           |   |                                 | Death (Check on                            |                          |   |   |                    |
| 5              | hysi<br>this c   | ၉              | 1 Yes 2 No  |                       |                                     | nt 2 ER/Outp                      | _                         |   |                                 | ng Home 5                                  |                          |   | pecify)   |                    |
| Division       | tending Ph<br>eeth.<br>or: After th<br>the funeral   | Certification: | 27. Manuar of Death  1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not  | ion (Mc               | e of Injur<br>onth, Day             | Year) Inj                         | jury                      |   | at<br>?<br>es 2 □ No            |  |                          | ury occurred                            |   |                    |
| 20             | e Hospital or Attendi<br>24 hours efter deeth<br>Funerel Director: A<br>etely filled in by the fo  | Certifi        | 4 Homicide determine  | ed 286. Pla<br>bui    | lding, etc                          | ry - At home, farr<br>. (Specify) |                           |   |                                 | City or                                    | Town, Sta                | te)                                     | Rural Route Nur   | nber,              |
|                | To the Hospital or Attending Physician: within 24 hours effer deeth. To the Funeral Director: After this certifica completely filled in by the funeral director,   | Medical        | 29a. Certifier 1 Certifying (Check only one) 2 Medical Ex   | aminer: On the        | he best of<br>basis of<br>anner sta | examination and                   | death<br>/or inve         | occurred at the timestigation, in my op   | e, date and p<br>inion, death o | lace, and due to to<br>occurred at the tin | he cause(<br>ne, date ar | s) and manner<br>nd place, and o        | as stated.<br>lue to the cause(                                     | s)                 |
|                |  | Σ              | 29b. Signature and title of certifier   | soul                  | PH                                  | 151CIAN                           |                           | 29c. License                              | number<br>3:590                 |  | 29d. D                   |   | nnth, Day, Year)  |                    |
|                | 3  |                | 30. Name and address of person wh   | 10 12                 | 004                                 | 600                               | -                         | rint) 624                                 | N                               | BROAD.                                     | N AM                     | 2120                                    | 5   |                    |
|                | Sta  | ite            | 31. Date filed (Month, Day, Year)   | 32.                   | Pegistra                            | r's Signature                     | -                         |   | , -, 04                         | JC 1 (1                                    | -                        |   |   |                    |
|                | Regist   |                | JUL 06  | 2006                  | BARA                                | r's Signature                     | COL                       | West -                                    |                                 |  |                          |   |   |                    |

06-04885 Benjamin Bong

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Year **Medical Examiner** Benjamin Gamalie1 July 10, 2006 0344 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5 Social Security Number If Under 1 Year If Under 24Hrs. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Months Days 21 Hours Director None Country) Maryland 1 X M 2 05/19/2006 Usual Residence of Decedent 10c. City, Town or Location Ę 10a State 10b. County 10d Inside City Limits Yes 2 X No 28a-f show Gaithersburg Maryland Montgomery nours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 23a or 20877 8266 Amity Circle United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 X Never Married 2 Married 2 X No Yes Divorced Yes, Give Year Yes 2 X No specify Widowed Specify: Asian ⋧ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 tent of Health and Mental Hygiene ant: If item 27 is marked other than "or other traumatic event, the Medical. த Baltimore, MD 21215-0036 2 should be filed within and Mental Hygiene None None 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Hendry Bong Veronica Hartanto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Hartanto / Mother 8266 Amity Circle; Gaithersburg, Maryland 20877 Veronica Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ment fant: Gate of Heaven Cemetery 7/13/2006 Silver Spring, MD 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center
1040 Rockville Pike; Rockville, Maryland 20852
23a Part I Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line. Donation 5 Other Specify: Approximate Interval **Physician** /Medical Death Sudden unexplained death in infancy (SUDI) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X UNPENDED signed by the attending physician be detached for use as the burial **AMENDED** item#23a,27,28a-f,perME,g860, 10/11/06 TT P.O. Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 certificate No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital 1 Inpatient 2 ✔ ER/Outpatient 3 Other<sub>4</sub> DOA Nursing Home 5 Residence 6 1 🗸 Yes No Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c Injury at Work' 28d Describe how injury occurred Certification: Natural Yes 2 No 5 Pending death Director: Fnd 7/10/2006 Fnd 3:15 am ımk Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8266 Amity Circle Caithersburg, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be determined residence Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only within 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 10, 2006 30. Name and address of person who completed cause of ceath (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore King MD.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month Day)

egistrar's Signatur

2006

|                                     |  |                  | 1 - For State Registrar   |  | aryland / D                   | epartment of h  | Health and M                      | -                                   | ne                           | 22784   |
|-------------------------------------|--|------------------|---|--|-------------------------------|---|-----------------------------------|-------------------------------------|------------------------------|---|
|                                     |  | To ja            | 1. Decedent's Name (First, Middle, Las  | it)                                      |                               |   |                                   | 2. Date of Death                    | Dau V                        | 3. Time of Death                                  |
| _                                   | Physicia<br>/Medic   |                  | Margaret Sylv:  | ia Peggy                                 | Bell                          |   |                                   | July 2,2                            | 2006 Yea                     | 10:15p <sup>M</sup>                               |
|                                     | Examin   |                  | 4a. Facility Name (If not institution, give   |  |                               | 4b. City, Town, o   | or Location of Death              |                                     | 4c. County of De             |   |
|                                     |  |                  | Union Hospita:  | L  |                               | E1ktor  | n                                 |                                     | Ceci1                        |   |
| * 1                                 | Funeral  |                  | Social Security Number     6. S   | 9x 7. Age<br>□ M <b>3</b> √□ F           | e (In yrs. last birth         | Months Days   |                                   | 8. Date of Birth<br>(Month, Day, Ye | 9. B                         | inthplace (State or Foreign<br>Country)           |
| - 0                                 | Director   |                  | 215-24-0119   | UM AUF                                   | 79 Y                          | rs.   |                                   | October 13,                         | 1926                         | MD  |
|                                     | and  |                  | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Town               | or Location   |                                   |                                     |                              | 10d. Inside City Limits                           |
|                                     | Aaryl<br>f aho   | ō                | MD Cecil  |  | Contille                      |   |                                   |                                     |                              | 1 XYes 2 □ No                                     |
|                                     | 28a-   | rect             | MD Cecil  10e. Sfreet and Number  |  | Cecilto                       | 10f. Zip Code   |                                   | 100                                 | Citizen of What (            | Country?  |
|                                     | with<br>3a or  | <u> </u>         | 645 Knight Islan  | A PA                                     |                               | 21913   | 3                                 |                                     | J.S.A.                       | 500mmy.   |
|                                     | n 72 hours after death with the Maryland<br>"natural", or Heme 23a or 28a-f ahow<br>adical Ezacutar Invest be notified at  | Funeral Director | 11. Marifal Status  | 12. Was Decedent I<br>Armed Forces?      | Ever in U.S.                  | 13. Was Decedent of the lif Yes, specify Cub                                |                                   |                                     | 14. Race - Ar                | nerican Indian,                                   |
| - 6                                 | or Ite   |                  | 1 ☐ Never Married 2 ☑ Married   | 1 ☐ Yes 2 📆 N                            |                               |   |                                   | o Rican, etc.)                      | Btack, W                     |   |
| 03                                  | ral', c  | by               | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates:           |                               | 1 ☐ Yes 2 🔀 No  | Specity:                          |                                     | Specify:                     | wnite   |
| 200                                 | within 72 hours after<br>ene.<br>than "natural", or Ite  | Completed        | 15. Decedent's Ed<br>(Specify only highest gra  | lucation<br>de completed)                | 16a. [                        | Decedent's Usual Occup<br>Give kind of work done<br>life. DO NOT use retire | pation<br>during most of work     | kina 16t                            | . Kind of Busines            | ss/Industry                                       |
| 21                                  | of new man   | ф                | Elementary/Secondary (0-12)   | College (1-4or 5                         | )+)                           |   | ed)                               |                                     |                              |   |
| . 121                               | led w<br>lygier<br>her ti  |                  | 11 17. Father's Name (First, Middle, Last)  | _  | Su                            | pervisor  | 10 14-14-1-1                      | - (C) - 14: dell 14:                | Perfect                      | : Books   |
| and O                               | be fi  | Be               |   |  |                               |   |                                   | ne (First, Middle, Mai              | den Sumame)                  |   |
| <u>~</u>                            | d Mer<br>d Mer<br>nark   | 1º               | Frank Arnold  | E Delan                                  | 101                           | 11.5  | Blanch 1                          |                                     |                              |   |
| Mai                                 | d 2 st<br>h and<br>7 ts n<br>traun   |                  | 19a. Informant's Name/Relationship (  |  |                               | Mailing Address (Street   |                                   |                                     |                              | , Zip Code)                                       |
| (c) (d)                             | 1 and<br>Heali<br>em 2<br>ther   |                  | Samuel J. Bell, J<br>20a. Method of Disposition   | r./Son                                   | 20b. Place of I               | B Nottingha<br>Disposition (Name of   |                                   |                                     | 21921<br>: Location - City ( | or Town State                                     |
| ٥ إ                                 | ages<br>nt of<br>r: If It  |                  | 1 ☐Burial 2 ☐ Cremation 3 ☐   |  | cemetery                      | , crematory or other pla  |                                   | 1                                   | · ·                          |   |
| Pegg<br>Baltimore                   | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, ILE MeanGES. |                  | 4 Donation 5 Other (Specify 21. Spatter of Superal Service Licen  |  | Oak La                        | wn Cemetery 22. Name and Addre  |                                   | 6,2006 E                            | Baltimore                    | =, MID  |
| G B                                 | Dermi<br>Depa<br>Impo<br>any Ir  |                  |   |  |                               | Andrew G.   | Gee Fune                          |                                     |                              |   |
|                                     |  |                  | 23a. Part1. Enfer the disease, or som   | plications that caused                   | the death. Do no              | 259 E. Mai  | n St., E.<br>ing, such as cardiac | Lkton, MD<br>or respiratory arrest, | 21921                        | Approximate                                       |
|                                     | Dhusisian  |                  | Immediate Cause (Final  | one cause on each in                     | ne.                           |   | 34                                | **                                  |                              | Interval Between<br>Onset and Death               |
|                                     | Physician /Medical   |                  | disease or condition resulting in death)  | a. Chun                                  | a consequence of              |   | idray de                          | rasi-ene                            | stage                        | unk   |
| rgw                                 | Examiner   |                  |   | CONOMA                                   | A consequence of              | Dane Oan  | 00:                               |                                     |                              | Unk   |
|                                     |  | er               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as                            | a consequence of              | ):  | 36° Jr                            |                                     |                              |   |
|                                     | outed<br>ansit   | Examiner         | Cause (Disease or injury that initiated events  | . Conger                                 | tive h                        | east low  | lure                              |                                     |                              | UNIC  |
| ó                                   | be execut<br>icien and<br>burial-trar  |                  | resulting in death) Last  | Due to (of as                            | a consequence of              | ):  |                                   |                                     |                              |   |
| 1760,                               | 9 %  | cai              | •   | d  |                               |   |                                   |                                     |                              |   |
| 89                                  | ng pt<br>as ti   | Physician/Med    | IF FEMALE:  |  |                               |   |                                   |                                     |                              |   |
| õ                                   | th ce  | an/l             | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome 1 ☐ Live birth      | of pregnancy<br>2 Fetal death | 3 □Ectopic pregnanc   | cy                                |                                     | 23d. Date of o               |   |
| E                                   | e des<br>the al  | sici             | 1 Yes 2 No  | 4 Pregnant at<br>9 Unknown               | time of death                 | 5 Other (specify)   |                                   |                                     | Month                        | Day Year  |
| P.0                                 | The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th  | F.               |   | antibuting to death b                    | ut ant requiting in           | No.   | De Al                             | ana Didasha                         |                              |   |
| Ś                                   | signe<br>bed<br>bed  | þ                | Part II. Dther significant conditions of  |  | ut not resulting in           | me underlying cause gi  | ven in Part I.                    | 1 ☐ Yes                             | 1                            | fo the cause of death?  Probably 4 Unknown        |
| 0.0                                 | law require<br>as been si<br>2 should b  | Completed        | 11  | knsion                                   |                               |   |                                   | 1 105                               | 2 0 3 🗆                      | Probably 4 Donkhown                               |
| Sec.                                | e 2 s  | npl              | tryper.   | knsion                                   |                               |   |                                   | 24a. Was an autopsy                 | prior to                     | autopsy findings available completion of cause of |
| <u> </u>                            | : The  | Co               |   |  |                               |   |                                   | performed<br>1 ☐ Yes 2 🔀            |                              |   |
| Vitt.                               | tician: The lav<br>certificate has<br>rector, page 2   | Be               | 25. Was case referred to medical examiner?  | Hospital:                                |                               | -   |                                   | th (Check only one)                 |                              |   |
| of                                  | Phys<br>this<br>al dir   | - To             | 1 ☐ Yes 2 No  27. Manner of Death   | 1 Sunpatie                               |                               | Datient 3 DOA   |                                   | ome 5 Residence                     |                              | pecity)   |
| LO LO                               | ding<br>In<br>After<br>funer   | ion              | fXNatural 5 ☐ Pending   | 28a. Dafe of Injui<br>(Month, Da)        | ry Year) 28b. Ti              | ury Wo  | ork?<br>]Yes 2 ☐No                | 28d. Describe how i                 | njury occurred               |   |
| isi                                 | deatl<br>deatl<br>ctor:<br>/ the   | ical             | 2 Accident investigation 3 Suicide 6 Could not b  |  | ury - At home, fare           | n, street, factory, office  |                                   | 28f Location (Stree                 | t and Number or              | Rural Route Number,                               |
| Division of Vital Records, P.O. Box | after<br>Direction by  | Certification:   | 4 Homicide determined   | building, etc                            | c. (Specify)                  | in, street, factory, office   |                                   | City or Town, S                     | itate)                       | nurai noute ivumber,                              |
| _                                   | spita<br>tours<br>neral  |                  | 29a Cartifier 12 Lartifying Ph  | yeldien: To the best.                    | of my knowladge,              | death conurse at the ti   | www. data and clace               | and due to the cauc                 | U(s) and nianner             | an etated   |
|                                     | e Ho   | edicai           | (Check only 2 Medical Examone)  | niner: On the basis of<br>and manner sta | f examination and             | or investigation, in my   | opinion, death occu               | rred at the time, date              | and place, and d             | ue to the cause(s)                                |
|                                     | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page   | Me               | 29b. Signature and title of certifier   |  |                               | 29c. Licens   | se number                         | 29d.                                | Date signed (Mo              | nth, Day, Year)                                   |
|                                     |  |                  | Metal   | M.D.                                     |                               | Do  | 0646                              | 70                                  | 01-                          | 02-2006   |
|                                     | /  |                  | 30. Name and addr = s of person who   | completed cause of d                     | leath (Item 23a) (1           |   |                                   |                                     |                              |   |
| 17                                  | 5  |                  | MONIQUE PRAT-UN   | whomp , El                               | o lim                         | IN HOSPITAL   | 106 BOL                           | ST. ELKA                            | OM, MO                       | 21921   |
| 43                                  | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)   | 32. Registra                             | ar's Signature                | 6)  |                                   |                                     | ,                            |   |

|                            |  |                  | For State ANGENERAL ANGENERAL  | State of Ma                            | •                  | •                         |                          |                         | ealth a                            |                 |                                | _                      | 4 U U                 | 6         | 22785                               |
|----------------------------|--|------------------|--|--|--------------------|---------------------------|--------------------------|-------------------------|------------------------------------|-----------------|--------------------------------|------------------------|-----------------------|-----------|-------------------------------------|
|                            | _  |                  | Registrar AMEND#14perFH7  1. Decedent's Name (First, Middle, Last            |  | <u> </u>           |                           | linear                   | 011                     | Jean                               |                 | 2. Date of De                  | R <b>eg. No</b><br>ath | ).<br>                |           | 3. Time of Death                    |
| П                          | Physicia   |                  | Hilario Arias  | Chavez                                 |                    |                           |                          |                         |                                    |                 | Month July 1                   | Da<br>L, 2             | 9<br>006              | ear       | 4:06 p M                            |
|                            | /Medio<br>Examin   |                  | 4a. Facility Name (If not institution, give                                  |  |                    |                           | 4b. City                 | Town, or                | Location of                        | of Death        | oury 1                         |                        | . County of           | Death     | <del></del>                         |
|                            | LAGITILI   | ٠.               | Washington Advent  | ist Hospi                              | tal                |                           | Tako                     | ma P                    | ark                                |                 |                                |                        | Monte                 | game      | ery                                 |
|                            | Funeral  |                  | 5. Social Security Number 6. Se  | x 7. Ag                                | e (In yrs. last    | birthday)                 | If Unde<br>Months        | T 1 Year<br>Days        | If Under:                          | 24 Hrs.<br>Min. | 8. Date of Birt<br>(Month, Da  | h<br>v. Year           | 9                     | . Birthr  | place (State or Foreign<br>ntry)    |
|                            | Director   |                  | 5//-15-8218  | ]M 2□F                                 | 70                 | Yrs.                      | Working                  | - Guyo                  | 110010                             |                 | Jan 14,                        |                        | 36 I                  | El S      | Salvador                            |
|                            | and *  | ł                | Usual Residence of Decedent  10a, State 10b, County                          |  | 10c. City, T       | own or Lo                 | cation                   |                         |                                    |                 |                                |                        |                       | 1.        | 10d. Inside City Limits             |
|                            | Maryli<br>f sho  | ō                | MD Montga  | nerv                                   | Sil                | ver !                     | Sprin                    | a                       |                                    |                 |                                |                        |                       |           | 1 ☐ Yes 2 ☐ No                      |
|                            | the the 288  | 90               | 10e. Street and Number   | псту                                   | 011                |                           | 10f. Zi                  |                         |                                    |                 |                                | 10g. Cit               | tizen of Wh           | at Cour   | ntry?                               |
|                            | 3a or  | Funeral Director | 10903 Fiesta Road  |  |                    |                           | 20                       | 901                     |                                    |                 |                                | El                     | Salva                 | ado:      | r                                   |
|                            | deati  | ner              | 11. Marital Status   | 12. Was Decedent<br>Armed Forces?      | Ever in U.S.       | 13.                       | Was Dece                 | dent of Hi              | spanic Orig                        | gin? (Spe       | cify Yes or No<br>Rican, etc.) | -                      |                       |           | can Indian,                         |
| ဖွ                         | or Ite   | 교                | Never Married 2☐ Married   | 1 ☐ Yes 2 ☑                            | No                 |                           |                          | •                       |                                    |                 | adoriar                        | 1                      | Salva<br>Specify:     | idor      | rian                                |
| 8                          | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or fleme 23a or 28a-f show<br>int, the Madical Examinar must be notified at  | d by             | 3 Widowed 4 Divorced   | Year or Dates:                         |                    |                           |                          |                         |                                    |                 |                                |                        |                       |           |                                     |
| 2                          | "nat   | Completed        | 15. Decedent's Edu<br>(Specify only highest grad                             |  | 1                  | 6a. Dece                  | dent's Usu<br>kind of wo | al Occupa<br>ork done d | ation<br><i>furing m</i> osi<br>') | t of workir     | ng                             | 16b. K                 | (ind of Busin         | iess/in   | dustry                              |
| 7                          | within<br>than   | E C              | Elementary/Secondary (0-12)  | College (1-4or 5                       | i+)                |                           | shwas                    |                         | /                                  |                 | :                              | т+                     | alian                 | Re        | staurant                            |
| 0                          | Hyg<br>other   | BeC              | 17. Father's Name (First, Middle, Last)                                      |  |                    | DI.                       | SIIWAC                   | IICL.                   | 18. Mothe                          | er's Name       | (First, Middle,                |                        |                       | 1101      | Jedazane                            |
| a                          | Alenta<br>Alenta<br>rked<br>tlc ev   | LO B             | Cupertino Arias  |  |                    |                           |                          |                         | Gr                                 | egor            | ia Chá                         | ivez                   |                       |           |                                     |
| Maryland 21215-0036        | and h  |                  | 19a. Informant's Name/Relationship (T)                                       | rpe, Print)                            | 1                  | 19b. Mailir               | ng Addres                | S (Street a             | and Numbe                          | er or Rura      | Route Number                   | er, City               | or Town, Sta          | ate, Zip  | Code)                               |
| Σ.                         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene.  Depertment of Health and Mental Hygiene.  Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be notified at once. |                  | Antonio Hernandez  | (Friend)                               |                    |                           |                          |                         |                                    |                 | Spring                         |                        |                       |           |                                     |
| Baltimore,                 | Pages 1<br>ment of H.<br>ant: If Iter<br>ury or oth  |                  | 20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ I                    | Removal from State                     | 20b. Place<br>ceme | e of Dispo<br>etery, crei | nsition (Na              | me of<br>other plac     | θ)                                 | - D             | ate                            | 20c. L                 | ocation - Ci          | y or To   | own, State                          |
| Ē                          | tant:  |                  | 4 ☐ Donation 5 ☐ Other (Specify)   |  | Inti               |                           | Ceme                     |                         |                                    |                 | 0-06 I                         | a U                    | nion,                 | El S      | Salvador                            |
| Bai                        | Deperminent mpor in since.   |                  | 21. Signature of Funeral Service Licens                                      | *                                      | 3                  | A·                        | ustir                    | Rov                     | s of Facilit<br>ster               | Fune            | ral Hon                        | ne                     |                       |           |                                     |
|                            | 10104  |                  | 23a. Part1. Enter the disease or comp  | lications that caused                  | Libe death F       |                           | 821_1                    | $4 \pm h^{-}$           | Stree                              | et_NW           | Washir                         | igto                   | n, DC                 | 20        | 0011<br>Approximate                 |
|                            |  |                  | shock, or heart failure. List only of<br>Immediate Cause (Final              | ne cause on each li                    | 10.                | 30 1101 0111              | 01 (110 1110             | 30 or ayırı             | g, 34011 43                        | oaraiao o       | rospilatory at                 | 1031,                  |                       |           | Interval Between<br>Onset and Death |
|                            | Pnysician<br>/Medical  |                  | disease or condition resulting in death)                                     | a. Cardi<br>Due to (or as              | o pulo             |                           | y Arı                    | rest                    |                                    |                 |                                |                        |                       | +         |                                     |
|                            | Examiner   |                  |  |  | rent c             |                           | r (He                    | ad a                    | nd Ne                              | ck)             |                                |                        |                       |           |                                     |
|                            | A SAME   | Je.              | f any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as                          |                    |                           | 1 1110                   | au u                    | 110 140                            | cat j           |                                |                        |                       | 1         |                                     |
|                            | cuted  | Examiner         | that initiated events  | c                                      |                    |                           |                          |                         |                                    |                 |                                |                        |                       |           |                                     |
| Ö,                         | The law requires that the death certificate be executed the seben signed by the attending physicien and bage 2 should be detached for use as the burial-transit  | E                | resulting in death) Last   | Due to (or as                          | a consequen        | ce of):                   |                          |                         |                                    |                 |                                |                        |                       |           |                                     |
| 8760,                      | cate to  | dical            |  | d                                      | - "                |                           |                          |                         |                                    |                 |                                |                        |                       | -         |                                     |
| 9<br>×                     | death certifica<br>attending ph<br>of for use as the   | 0                | IF FEMALE:   | 23c. If yes, outcome                   | of pregnancy       | ,                         |                          |                         |                                    |                 |                                |                        | 00d D-14              | d delic   |                                     |
| Вох                        | that the death cer<br>ed by the attendir<br>detached for use   | Physician/M      | in the past 12 months?   | 1 ☐ Live birth<br>4 ☐ Pregnant at      | 2 Fetal de         | ath 3[                    | Ectopic p                |                         |                                    |                 |                                |                        | 23d. Date of<br>Month |           | ery<br>Day Year                     |
| P.O.                       | the d<br>y the<br>ached  | ysk              | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 9□ Unknown                             |                    |                           | 3 0 (0)                  |                         |                                    |                 |                                |                        |                       |           |                                     |
|                            | s that<br>ned b  | by PI            | Part II. Other significant conditions co                                     | ntributing to death b                  | ut not resultin    | ng in the u               | nderlying (              | ause give               | en in Part I.                      |                 | 23e. Did to                    | obacco                 | use contribu          | ite to th | he cause of death?                  |
| g                          | w requires to been signed should be  | ed tr            |  |  |                    |                           |                          |                         |                                    |                 | 101                            | es 2                   | <b>∑</b> No 3         | ] Prob    | oably 4 Unknown                     |
| 000                        | law re   | plet             |  |  |                    |                           |                          |                         |                                    |                 | 24a. Was                       |                        | 24b. We               | re auto   | ppsy findings available             |
| ž                          | The lay<br>ate has<br>page 2   | Completed        |  |  |                    |                           |                          |                         |                                    |                 | autop<br>perfo<br>1 ☐ Yes      | rmed?                  | dea                   | th?       | mpletion of cause of                |
| ita                        | Physician: Th<br>rthis certificate<br>ral director, pag  | Be               | 25. Was case referred to medical examiner?                                   |  |                    |                           |                          |                         | 26. Place                          | of Death        | (Check only o                  |                        |                       |           |                                     |
| 5                          | Physical this call dire  | မ                | 1√ Yes 2□ No   | Hospital: 1 ☐ Inpatie                  |                    | /Outpatier                |                          |                         |                                    |                 | ne 5 🗆 Resid                   |                        |                       | (Specif   | y)                                  |
| Ë                          | ding F   | on:              | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending                                  | 28a. Date of Inju<br>(Month, Da        | y Year) 28         | b. Time o<br>Injury       |                          | 28c. Injury<br>Work     |                                    |                 | 8d. Describe I                 | now inju               | ry occurred           |           |                                     |
| <u>is</u>                  | Attending<br>r death.<br>ector: After<br>by the fune   | icat             | 2 Accident investigation 3 Suicide 6 Could not be                            | 28e. Place of Inj                      | uny - At home      | farm et                   | M lactor                 |                         | Yes 2 □ I                          |                 | Rf Location /                  | Street ar              | nd Number             | or Pur    | al Route Number.                    |
| Division of Vital Records, | I or Atten<br>after deat<br>Director:  | Certification:   | 4 Homicide determined  | building, et                           |                    | , 14,111, 311             | eer, ractor              | y, onice                |                                    |                 | City or Tov                    |                        |                       | ii nuie   | u noute Number,                     |
|                            | To the Hospital or Attending Physician: The within 24 hours alter death.  To the Funeral Director: After this certificate h completely illed in by the funeral director, page  |                  | 29a. Certifier 1 Certifying Phy  | sician: To the best                    | of my knowled      | dge, deat                 | h occurred               | at the tim              | ne, date an                        | d place, a      | nd due to the                  | cause(s                | ) and mann            | er as s   | tated.                              |
|                            | he Ho<br>in 24 I<br>he Fu<br>pletel  | edical           | (Check only 2 Medical Exam one)  | ner: On the basis of<br>and manner sta | examination        | and/or in                 | vestigation              | n, in my op             | oinion, deat                       | th occurre      | d at the time,                 | date and               | d place, and          | due to    | the cause(s)                        |
|                            | To t<br>To t   | Ž                | 29b. Signature and title of certifier  |  |                    |                           | 29                       | c. License              | number                             |                 |                                |                        | te signed (/          |           |                                     |
|                            | 4  |                  | Lamor  | - ) M                                  | D                  |                           |                          | DC                      | 06010                              | 00              |                                | 7                      | -06                   | , –       | 56                                  |
|                            | ţ  |                  | 30. Name and address of person who c   | ompleted cause of d                    |                    |                           |                          | -                       |                                    | 502             | . 12                           |                        |                       | 0.5.5     | _                                   |
|                            |  |                  | 31. Date filed (Month, Day, Year)  | M. D. Sanietr                          | ar's Signature     | reit                      | y Bl                     | va. <del>-</del> E∂     | st. S                              | 51 LVC          | r Seru                         | 10+                    | MD 2                  | 090       | 3                                   |
|                            | Sta<br>Registi   |                  | 4 00 00  | 106                                    | ar's Signature     | A CO                      | ali                      |                         |                                    |                 |                                |                        |                       |           |                                     |

|             |  |                  | 1 - For<br>State<br>Registrar   | State of   |   | d / Depa                        | artme            | nt of H                      |  | and Me                     | ental Hy                        |                    | / 11111  | 5 2                                 | 2786                          |
|-------------|--|------------------|---|--|---|---------------------------------|------------------|------------------------------|--|----------------------------|---------------------------------|--------------------|--|-------------------------------------|-------------------------------|
|             |  |                  | Decedent's Name (First, Middle  | , Last)  |   |                                 |                  |                              |  |                            | 2. Date of De                   | ath                |  | 3. Tin                              | ne of Death                   |
|             | Physici<br>/Medi   |                  | Lidia Lorena  | Cabrejas   |   |                                 |                  |                              |  |                            | Month<br>July                   | 4, Da              | 2006 Υθαι                                      | 7:                                  | 40 a м                        |
| j.          | Examir   |                  | 4a. Facility Name (If not institution   | , give street and numb                                     | oer)  |                                 | 4b. Cit          | y, Town, or                  | Location of                              | of Death                   |                                 | 40                 | . County of Dea                                |                                     |                               |
|             |  |                  | Montgomery Hos  | snice- Case  | ev Hous   | s.e                             | R                | ockvi                        | 11e                                      |                            |                                 |                    | Montgom  | erv                                 |                               |
|             | Funeral  |                  | 5. Social Security Number   | 6. Sex 7.  | . Age (In yrs.                                  |                                 | If Und<br>Months | er 1 Year<br>Days            | If Under<br>Hours                        | 24 Hrs.                    | 8. Date of Bir<br>(Month, Da    | th                 |  |                                     | tate or Foreign               |
|             | Director   |                  | 577-64-3148   | 1 □ M 25€ F  | 81  | Yrs.                            | WORKE            | Days                         | riours                                   |                            | Aug. 3                          | , 19               | 24 Cu  |                                     |                               |
|             | D .  |                  | Usual Residence of Decedent  10a. State 10b. County   |  | 100 Cit   | y, Town or Lo                   | antine.          |                              |  |                            |                                 |                    |  | 104 100                             |                               |
|             | anyla<br>shov  | -                | Toa. State  |  | 100.00  | y, rown or Ec                   | ocation          |                              |  |                            |                                 |                    |  |                                     | de City Limits Yes 21 No      |
|             | Ne M   | octo             |   | gomery   |   | Wheat                           |                  |                              |  |                            |                                 |                    |  | 1                                   | 165 246 140                   |
|             | within 72 hours after deeth with the Maryland<br>ene.<br>than "natural", or items 23e or 28e-1 show<br>ta Medical Examinar must be notified at   | Funeral Director | 10e. Street and Number  |  |   |                                 | 10f. 2           | ip Code                      | _  |                            |                                 | 10g. C             | itizen of What Co                              | ountry?                             |                               |
|             | s 23s  | rai              | 11919 Lafayette   |  |   | 0   1                           |                  | 2090                         |  |                            |                                 |                    | USA  |                                     |                               |
|             | er de<br>Item  | Ľ,               | 11. Marital Status  | 12. Was Deced  | <i>e</i> s?                                     | .S. 13.                         | Was Dec          | edent of Hi<br>ecify Cuba    | ispanic Ori<br>in, <mark>Mexica</mark> n | gin? (Spec<br>n, Puerto R  | ify Yes or No<br>ican, etc.)    | -                  | <ol> <li>Race - Ame<br/>Black, Whit</li> </ol> | erican India<br>10, etc.            | ın,                           |
| 36          | rs aft   | by F             | 1 □ Never Married 2 1 Marri<br>3 □ Widowed 4 □ Divorced   | ed 1 □ Yes 2<br>If Yes, Give<br>Year or Dat                |   |                                 | 1 🔀 Y <i>e</i> s | 2□ No                        | Specify:                                 | Cubar                      | า                               |                    | SpecifyWhi                                     | te                                  |                               |
| 21215-0036  | hou ture   | ba               | 15. Decedent  |  | -   | 16a. Dece                       | dent's He        | ual Occupa                   | ation                                    |                            |                                 | 16h k              | Cind of Business                               | Andustas                            |                               |
| 15          | in 72<br>in 72   | Completed        | (Specify only highes  | t grade completed)   |   | (Give                           | kind of v        | vork done o                  | during mos                               | t of working               | g                               | 100.1              | and or odsiness                                | industry                            |                               |
| 12          | with<br>the  | E                | Elementary/Secondary (0-12)   | College (1-4   | or 5+)  |                                 | mema:            |                              |  |                            |                                 | Ow                 | m Home   |                                     |                               |
| D           | filled<br>Hyg<br>other   |                  | 17. Father's Name (First, Middle,   | Last)  |   |                                 |                  |                              | 18. Mothe                                | er's Name (                | (First, Middle,                 |                    |  |                                     |                               |
| lan         | id be<br>ental<br>ked<br>ic ev   | To Be            | Jose Urtiaga  |  |   |                                 |                  |                              | Amer                                     | rica E                     | Batlle                          |                    |  |                                     |                               |
| Maryland    | shound M   | -                | 19a. Informant's Name/Relations   | nip (Type, Print)  |   | 19b. Maili                      | ng Addre         | ss (Street a                 | and Numbe                                | er or Rural                | Route Numb                      | er, City           | or Town, State,                                | Zip Code)                           |                               |
|             | nd 2<br>oith a<br>27 is  |                  | Joaquin Cabre   | jas/ Husbaı  | nd  | 119                             | 19 L             | afaye                        | tte D                                    | rive,                      | Wheat                           | ton,               | MD 209   | 02                                  |                               |
| Baltimore,  | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show minjetury or other traumatic event, tra Medical Examination or other traumatic event, traumatical Examination or other traumatical events.  |                  | 20a. Method of Disposition  |  |   | Place of Dispo<br>emetery, crea | osition (N       | ame of                       |  | Da                         | ite                             | 20c. L             | ocation - City or                              | Town, Sta                           | te                            |
| 9           | and it is  | 1                | 1 ☑ Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (S)  |  | ate   | ce of He                        | -                | -                            |  | uly<br>2006                |                                 | C + 1              | ver Spr  | ina                                 | Manzzlan                      |
| Ħ           | ortan  |                  | 21. Signature of Funeral Service  |  |   |                                 |                  |                              |  |                            |                                 |                    | me Inc.  | riig,                               | матутан                       |
| ä           | Department  |                  | (mules)   | Colo   | ,   |                                 |                  |                              |  |                            |                                 |                    | r Sprin  | g, MD                               | 20901                         |
| ,160,       | Medical Examiner Assignment Assig | ical Examiner    | resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or Due to (or c.                                   | r as a conseq<br>r as a conseq<br>r as a conseq | uence of):                      |                  |                              |  |                            |                                 |                    |  |                                     |                               |
| P.O. Box 68 | hat the death certifica<br>od by the ettending ph<br>detached for use as th  | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant condition   | 4□Pregnar<br>9□Unknow                                      | h 2 ☐ Feta<br>nt at time of d<br>m              | I death 3[<br>eath 5[           | Other (          |                              |  |                            | 23a Did t                       | ohacco             | 23d. Date of del<br>Month                      | Day                                 | Year                          |
| Records,    | signe<br>d be  | Completed by     | Dementia  | •  |   |                                 | ooyiing          | oudoo g.v.                   | 21, 11, 7 41, 1.                         |                            |                                 |                    |  |                                     | 4 □Unknown                    |
| Ö           | w requir<br>been s   | ete              |   |  |   |                                 |                  |                              |  |                            |                                 |                    |  |                                     |                               |
| ž           | e lav  | I d              |   | <u> </u>   |   |                                 |                  |                              |  |                            | 24a. Was                        |                    | 24b. Were at prior to death?                   | itopsy findi<br>compl <i>e</i> tion | ings available<br>of cause of |
| <u>=</u>    |  |                  |   |  |   |                                 |                  |                              |  |                            | 1 □ Yes                         |                    |  | 2 □ No                              |                               |
| Vital       | Physician: The lav<br>this certificete has<br>al director, page 2  | Be               | 25. Was case referred to medical examiner?  | Hospital:  |   |                                 |                  | Othe Othe                    |  |                            | Check only o                    |                    |  |                                     |                               |
| ō           | £ 5 5  | - To             | 1 ☐ Yes 2 ☐ No 27. Manner of Death  | 1 ∐ Ing  | natient 2                                       | 28b. Time o                     |                  | , OA                         | 4 🗆 140                                  |                            | e 5 ☐ Resi                      |                    | 6 DOther (Spe                                  | cify)Hos                            | pice                          |
| 0           | iding Phy<br>th.<br>After this<br>funeral o  | 탈                | 1 Natural 5 Pendin  | q (Month,  | Day Year)                                       | Injury                          | M                | 28c. Injury<br>Work          | (?<br>Yes 2 🔲 I                          |                            | d. Describe                     | iow inju           | iry occurred                                   |                                     |                               |
| Division    | Attending r deeth.   | Certification:   | 3 ☐ Suicide 6 ☐ Could r   | not be   | f Injury - At h                                 | ome farm st                     |                  |                              | .00 2                                    |                            | of Location /                   | Street a           | nd Number or Ru                                | iral Bouto                          | Number                        |
| Θ           | after<br>Dire  | ert              | 4 ☐ Homicide determ   | building   | , etc. (Specif                                  | y)                              | 1001, 1401       | , y, omog                    |  |                            | City or To                      | wn, Stat           | θ)   | JAN TOURS                           | voilloer,                     |
|             | To the Hospital or Attendi within 24 hours after deeth. To the Funeral Director: A completely filled in by the fu  | Medical C        | 29a. Certifier XIX Certifyin (Check only 2 Madical  | g Physician: To the b<br>Examinar: On the bas<br>and manne | is of examina                                   | wledge, deat<br>ition and/or in | h occurre        | d at the tim<br>on, in my op | ne, date an<br>pinion, dea               | d place, an<br>th occurred | nd due to the<br>d at the time, | cause(s<br>date an | and manner as<br>d place, and due              | stated. to the cau                  | ise(s)                        |
|             | ompl   | Me               | 29b. Signature and title of certifier   | Α.   |   |                                 | 2                | 9c. License                  | number                                   |                            |                                 | 29d. Da            | ite signed (Mont                               | h, Day, Yes                         | ar)                           |
|             |  |                  | 1 / The   |  | WD  |                                 |                  | D356                         | 35                                       |                            |                                 | т.                 | J., 5  | 2000                                |                               |
|             | (D   |                  | 30. Name and address of person  | who completed cause  | of death (Iten                                  | n 23a) (Type                    | Print)           |                              |  |                            |                                 | Ju                 | ly 5,  | 2006                                |                               |
|             |  |                  | Joseph Kaplan,  | •  | 1 Munc  |                                 | •                | Road                         | . Roc                                    | kvill                      | e. MD                           | 208                | 55   |                                     |                               |
|             | Sta  | ate              | 31. Date filed (Month, Day, Year)   | 32. Peg  | gistrar's Signa                                 | ture                            | Carl.            | 9                            | , 1.00                                   |                            | - 0, FID                        |                    | J.J.   |                                     |                               |
|             | Regist   | rar              | JUL O   | 6 2006   | augus 1   | ture                            | AN CAL           |                              |  |                            |                                 |                    |  |                                     |                               |

Please Type or Print in Black Indelible Ink Bernard Cronk State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1 Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 11, 2006 0754 hrs Medical Examiner Bernard Merrel Cronk 4c County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Union Hospital Elkton Cecil 9. Birthplace (State or Foreign Pennsylvania Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) **Funeral** Months Davs Hours Min Director 1 X M 2 1937 194-30-8381 69 JAN 17. Usual Residence of Deceden 10a State 10c City, Town or Location 10d Inside City Limits any 10b Count 1 Yes 2 X No or 28a-f show Marvland Ceci1 Chesapeake City 'natural", or items 23a or 28a-f sho Examiner must be notified at once, Director 10e. Street and Number 10f Zin Code 10g Citizen of What Country? 35 Buddy Boulevard 21915 United States Funeral 13 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes permit. Pages I and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examiner n Yes, Give Year 1 Yes 2 X No specify 3 Widowed Divorced Specify White ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 Kennel Management County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Floyd Cronk Bernice Harvey 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Kathy M. Cronk/Wife 35 Buddy Boulevard, Chesapeake City, MD 21915 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition C Location - City or Town, State
West Chester, ltimore, crematory or other place) July 13, Burial 2 X Cremation 3 Removal from State R.A. Ferris & Co., Inc. Pennsylvania 2006 Other Specify <sup>22</sup> Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee smy art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and ian/Medical attending physician or use as the burial -UNPENDED AMENDED requires that the death certificate be Box 68760. 23c. If yes, outcome of pregnancy IE EEMALE 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day 2 past 12 months? Pregnant at time of death Physici 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? Ó þ 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✔ Yes 2 No 2 No ✓ Yes To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 Other Nursing Home 5 Inpatient 2 V ER/Outpatient 3 DOA Residence 6 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural 1 Yes 2 Pending the Investigation Accident 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town State) determined Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d Date signed (Month, Day, Year) 29b Signature and title of certifier O.C.M.E July 12, 2006 30 Name and address of person who completed cause of death (Item 23a) 10 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 20 DHMH 17 Rev 1/2001 **ORIGINAL** 

06-04928

Ruben Dominguez

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 22788

| `   | F             | - For State<br>Registrar   |  |                           | ate of Dea                           |                  |                                  | <u>F</u>                                   | Reg. No.   |                                  |  |  |  |
|---|---------------|--|--|---------------------------|--------------------------------------|------------------|----------------------------------|--|--|----------------------------------|--|--|--|
| Physicia  |               | 1. Decedent's Name (First, Middle,Las<br>Ruben   | Dominguez  |                           |                                      |                  |                                  | 2. Date of Dea<br>Month<br>July 1, 20      | Day Year   | 3. Time of Death<br>0002 hrs     |  |  |  |
| Cai Exami   |               | 4a. Facility Name (if not institution, giv   |  |                           | 4b. City,                            | Town, or         | Location of D                    |  | 4c. County of De                                       | ath                              |  |  |  |
|   |               | 1901 Erie Street   |  |                           | Adel                                 |                  |                                  |  | Prince George's  |                                  |  |  |  |
| Funeral<br>Director   |               |  | 7. Age (In yr  |                           | hday) If Und<br>Monti                | ths Day          |                                  | Min.                                       | 16,1986  | Birthplace (State or eign Mexico |  |  |  |
| â   | -             | Usual Residence of Decedent  10a. State 10b. County  | 10c. C   | ity, Town                 | or Location                          |                  |                                  |  |  | 10d. Inside City Limits          |  |  |  |
| Maryland<br>28a-f show any<br>d at once.  | 7             | MD Montgo  | mery S   | Silv                      | er Spri                              | ing              |                                  |  |  | 1 Yes 2 X No                     |  |  |  |
| 15-0036<br>filed within 72 hours after death with the Maryland<br>I Hygiene.<br>I other than "natural", or items 23a or 28a-f sho<br>i, the Medical Examiner must be notified at once.  | Öİr           | 10e. Street and Number<br>9119 Mancheste   | r Road   |                           |                                      | p Code<br>2090   | 1                                |  | 10g. Citizen of What C  Mexico                         | ountry?                          |  |  |  |
| ath with tems 2.  | Funeral       | 11. Marital Status  1 X Never Married 2 Married  | 12. Was Decedent Ever in<br>Armed Forces?                      |                           |                                      |                  |                                  | ? ( Specify Yes or N<br>uerto Rican, etc.) | o- 14. Race - Am<br>White, etc                         | nerican Indian, Black,           |  |  |  |
| fter der  |               |  | 1 Yes 2 X No   | 0                         | 1 X Yes                              | 2 No             | specify:                         | lexican                                    | Specify:   | White                            |  |  |  |
| ours a  | d b           | 15. Decedent's Education (Specify o  |  |                           | Decedent's Usua<br>during most of wo |                  |                                  |  | 16b. Kind of Busines                                   | ss/Industry                      |  |  |  |
| 21215-0036 Juld be filed within 72 hou Mental Hygiene. marked other than "nati  | Completed by  | Elementary/Secondary (0-12)  | College (1-4 or 5+)  |                           | Constru                              | _                | on                               |  | Paint  | Co.                              |  |  |  |
| 15-0<br>filed wall Hygio  | Be Co         | 17. Father's Name (First, Middle, Last Jorge Ruben D   | •  |                           |                                      |                  |                                  | Name (First, Middle,                       | ·  |                                  |  |  |  |
|   | 라             | 19a. Informant's Name/Relationship (   |  | 198                       | b. Mailing Addres                    | ss (Stre         | et and Numbe                     | a G. Lope<br>er or Rural Route Nu          | ar Z<br>Imber, City or Town, St                        | ate, Zip Code) 0 1               |  |  |  |
| e, MD 2<br>1 and 2 shou<br>Health and N<br>item 27 is n<br>r traumatic  |               | Laura G.Lopez  | /Mother  |                           |                                      | anch             | ester                            |  | ilver Spr<br>20c. Location - City                      | ing Md                           |  |  |  |
| W   |               | 20a. Method of Disposition  1 Burial 2 Cremation 3   | Removal from State   | cremat                    | ory or other place                   | e)               |                                  |  |  |                                  |  |  |  |
| Baltimore<br>permit. Pages I<br>Department of H<br>Important: If i  |               | 4 Donation 5 Other Specify 21. Signature of Funeral Service Licer                                  |  | hesa                      | apeake<br>122.Name.an                |                  |                                  | /09/06                                     | Beltsvi  | lle,Md                           |  |  |  |
| Balt<br>permit.<br>Depart<br>Import<br>Injury   | - 1           | 23a. Part   Enter the disease, or com  | 7  |                           | 9241                                 | LP D<br>Col      | .RINA<br>umbia                   | LDI FUNI<br>Blvd.S                         | ERAL SERV  | ICE,P.A.                         |  |  |  |
| Physician<br>/Medical   |               | failure. List only one cause on e  | ach line.  |                           | ot enter the mode                    | e of dying       | , such as care                   | diac or respiratory a                      | rrest, shock, or he rt                                 | Between Onset and                |  |  |  |
| žxaminer  |               | Immediate Cause (Final disease a or condition resulting in death)                                  | Multiple Gunshot Wo  |                           |                                      |                  |                                  |  |  | Death                            |  |  |  |
|   |               | Sequentially list conditions, b  | ,  |                           |                                      |                  |                                  |  |  |                                  |  |  |  |
|   | ine           | if any, leading to immediate cause. Enter Underlying Cause   | Due to (or as a consequence                                    | ce of):                   |                                      |                  |                                  |  |  |                                  |  |  |  |
| 760, icate be executed physician and the burial - transit   | I Examiner    | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): |  |                           |                                      |                  |                                  |  |  |                                  |  |  |  |
| D,<br>be exe<br>sician a  | Medical       | UNPENDED   | AMENDED  |                           |                                      |                  |                                  |  |  |                                  |  |  |  |
| Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | Physician/Me  |  |  |                           |                                      |                  |                                  |  |  |                                  |  |  |  |
| O. B<br>it the de<br>by the   |               | Part II. Other significant conditions  | Unknown  contributing to death but n                           | ot resultin               | g in the underlyir                   | ng cause         | given in Part                    | I. 23e. Did                                | tobacco use contribute                                 | to the cause of death?           |  |  |  |
| ires that isigned   | d by          |  |  |                           |                                      |                  |                                  | _  | ALLENSI BELLEVILLE                                     | Probably 4 V Unknown             |  |  |  |
| Division of Vital Records, P.O. ral or Attending Physician: The law requires that the saft cleath.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact  | ompleted      |  |  |                           |                                      |                  |                                  |  | opsy prior<br>formed? death                            |                                  |  |  |  |
| tal Fi  | BeC           | 25. Was case referred to medical examiner?   | Hospital:  |                           |                                      |                  | (Othor:                          | check only one)                            | •  |                                  |  |  |  |
| of Vid<br>Physic<br>er this   | ု             | 1 ✓ Yes 2 No<br>27. Manner of Death  | 28a. Date of Injury  |                           | Outpatient 3                         | DOA<br>28c. Inje | ury at Work?                     | Nursing Home 5                             | Residence 6 Of Of                                      | ther: Scene                      |  |  |  |
| on of<br>anding Pl<br>ath.<br>rr. After<br>he funera  | tion:         | 1 Natural 5 Pending  | FOUND:   | FOL                       | JND:<br>9 hrs                        |                  | Yes 2 V                          | Subject sh                                 |  |                                  |  |  |  |
| Division of Vital Recipital or Attending Physician: The Jours after death.  Reral Director: After this certificate iffled in by the funeral director, page  | ertification: | 2 Accident Investiga 3 Suicide 6 Could no determine  | t be 28e. Place of Injury -                                    | At home, fa               | arm, street, facto                   | ry, office       | building, etc.                   |  | (Street and Number or<br>State)<br>Street , Adelphi, I | Rural Route Number, City         |  |  |  |
| Division  To the Hospital or Attence within 24 hours after death To the Finneral Directors completely filled in by the  | Medical C     | 29a. Certifier 1 Certifying Physic   | cian: To the best of my knov<br>er:On the basis of examination | vledge, de<br>on and/or i | ath occurred at the                  | he time, o       | date and place<br>on, death occu | e, and due to the cau                      | use(s) and manner as s                                 | started.                         |  |  |  |
| F is is is  | Me            | 29b. Signature and title of certifier  | A f  |                           | 2                                    |                  | se number                        |  | 29d. Date signed (                                     | Month, Day, Year)                |  |  |  |
| $-\nu$  |               | Thooben M.   | 1/2 mm   |                           |                                      | 0.0              | .M.E.                            |  | July 1, 2006   |                                  |  |  |  |
|   |               | 30. Name and address of person who Theodore King MD. As  | completed cause of death (<br>ssistant Medical Exam            |                           | 111 Penn St                          | reet. Ba         | altimore. N                      | /ID 21201                                  |  |                                  |  |  |  |
|   | ate           | 21 Date filed (11-pg-g) V  | 32 Registrar's Sig   |                           | Boarles                              |                  |                                  |  |  |                                  |  |  |  |
| Regis   |               |  | Itilb Add a se   | 110                       | A COLUMN TO THE REAL PROPERTY.       |                  |                                  |  |  |                                  |  |  |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Lillian Beatrice DOUB 10, 2006 9:30 P M JULY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 18,1901 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 XF Months Days Hours 219-20-1082 104 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits Maryland 1⊠Yes 2 No Washington Hagerstown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 132 East Antietam Street 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☒ No Specify: white Completed by "natural" traumatic event, The Modical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) sandblasting equipment 12 secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should ba 1 nent of Health and Mental I ant: If item 27 Is marked of James Bucanan Manyett Laura Virginia Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen Colvin - grandson 130 Caspian Dr., Stephens City, Va. 22655 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o once. 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 7/13/06 \* 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Furieral Service Licenses - 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final beart ougestive **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner arterioscleratic cardiovascular burial-transit that initiated events resulting in death) Last the attending physician Physician/Medical usa as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à Lementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan certificate has 2 No 1 ☐ Yes 2 100 1 TYes 25. Was case referred to medical examiner? diractor. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending 1 Natural investigation after death Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide hin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier M.D. DO041131 30. Name of diaddress of person who completed cause of death (Item 23a) (Type, Print) coffects, un 1124 Opal court, Hagerstown, MD 21740 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baitimore, Maryland 21215-0036

Box 68760.

P.O.

of Vital

Division

**ORIGINAL** 

06-04429 Please Type or Print in Black Indelible Ink Robert Dickson Amend Item 21 per FH, G85/OFF00 Of The Begistrer Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 24, 2006 Medical Examiner Robert Brent Dickson, PhD 0949 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c County of Death Suburban Hospital Bethesda Montgomery 5 Social Security Number 6 Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYYY 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign Director Months Davs Hours Min 226-66-1667 1X M 2 54 June 13,1952 Country Wash DC Yrs Usual Residence of Decedent 10a State 10c. City, Town or Location ill. 10d Inside City Limits 28a-f show d at once. MD Montgomery Kensington 1 X Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 28 notified 9900 Hillridge Dr. 20895 United States Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 1 Never Married 2 X Married Armed Forces? White etc. Yes 3 Widowed Divorced If Yes. Give Year Yes 2X No specify. Specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Scientist 21215-0036 Cancer Research 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Robert Dickson Marie Altsheler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD If item 27 is Jane Fall-Dickson/Wife 9900 Hillridge Dr., Kensington, MD 20895 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 Removal from State crematory or other place) important: Gate of Heaven Cem Donation 5 Other Specify: 7-1-06 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility oseph Gawler's Sons, INC Leah M. Ross per DVR 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Between Onset and /Medical a Hemopericardium Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b Dissection of Thoracic Aorta Sequentially list conditions. if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician or use as the burial -Box 68760, IF FEMALE 23c. If ves. outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown signed by t. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ó Š of Vital Records, P. 1 Yes 2 No 3 Probably 4 V Unknown Completed peen 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? Yes 2 1 🗸 Yes 25. Was case referred to medical To the Hospital or Attending Physician: 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Division 5 Pending 1 Yes 2 No after death To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20 O.C.M.E. June 26, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner 31 Date filed (Month, Day, Year) Registrar's Signatur State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** A M Ju1y 2006 0830 Yolanda Palma DeJoise 12 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner E1kton Cecil Union Hospital 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F March 29, 1926 Pennsylvania Director 80 186-20-5725 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, Ira Mudical Examples Institled at ODEs. 1 ¥ Yes 2 □ No Directo Maryland Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 United States 31 Lambourne Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Nidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Furrier Salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Adeline Santoriella Eugene William Paterra 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 604 Stone Gate Boulevard, Elkton, Maryland 21921 Eugene W. DeJoise/Son altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
West Chester, 20a. Method of Disposition July 13, 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co., Inc. 2006 Pennsylvania 21. Sign ture of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPTIC SHOCK WITH MULTIORGAN /Medical Examiner PULMONARY EMBOLISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner COLON CANGE certificate be executed the burial-transit MEPASTATIC and Box 68760. physician use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, CARTINO INTESTINAL BUEGO 1 Yes 2 16 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? ANEMIA 24a. Was an page 1 ☐ Yes 2 ☐ No certificate 2 No 1 Yes or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death | Check on y one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Mpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending ar death. 1 Tyes 2 No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire Hospital 1 Certifying Physician: To the best of my knowledge, death opported at the time, date and place, and due to the basise(s) and manner as stated Medicai 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MATT M. D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. PRATT - USUNAMA, M.D. -13-2006 HOSEITAL 196 BOW STREET ELKTON, MO 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 0 2006 Registrar

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Registrar

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|            |   | •                | For<br>State<br>Registrar   | State of M  | arylan      |                                  | artmen<br>rtificat         |                    |                            | and M           | _                                     | gienę<br>Reg. No:    | 211116                         | 22794  |
|------------|---|------------------|---|---|-------------|----------------------------------|----------------------------|--------------------|----------------------------|-----------------|---------------------------------------|----------------------|--------------------------------|--|
|            | 2   |                  | 1. Decedent's Name (First, Middle   | , Last)   |             |                                  |                            |                    |                            |                 | 2. Date of De                         | ath<br>Day           | Year                           | 3. Time of Death                                     |
|            | Physicia<br>/Medic  |                  | Muriel C.   | Goforth   |             |                                  |                            |                    |                            |                 | July                                  |                      | 006                            | 6:45 p <sup>M</sup>                                  |
|            | Examin  |                  | 4a. Facility Name (If not institution   | , give street and number)   |             |                                  | 4b. City,                  | Town, or           | Location o                 | of Death        | o day                                 |                      | County of Dea                  | th   |
|            |   |                  | Kensington Nu   | rsing & Reha  | b. C        | enter                            | 1                          | sing               |                            |                 |                                       |                      | Mo                             | ntgomery   |
|            | Funeral   |                  | 5. Social Security Number   | 6. Sex 7. Ag  | e (In yrs.  | last birthday)                   | If Under<br>Months         |                    | If Under                   | 24 Hrs.<br>Min. | 8. Date of Bir<br>(Month, Da          | th<br>y, Year)       | 9. Bir                         | thplace (State or Foreign ountry)                    |
|            | Director  |                  | 578-44-0730   | 8   | 38          | Yrs.                             |                            |                    |                            |                 | Nov. 9                                |                      | 17 N                           | Maryland   |
|            | and w   |                  | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. Cit    | y, Town or Lo                    | ocation                    |                    |                            |                 |                                       |                      |                                | 10d. Inside City Limits                              |
|            | daryl<br>f sho  | ō                |   |   |             |                                  |                            |                    |                            |                 |                                       |                      |                                | 1 ☐ Yes 2 ☑ No                                       |
|            | the t   | Tec.             | Maryland Mo  10e. Street and Number   | ntgomery  | 1           | Ken                              | singt<br>10f. Zip          |                    |                            |                 |                                       | 10a. Citi            | zen of What C                  | ountry?  |
|            | Sa or   | Funeral Director | 3000 McComas A  | venue   |             |                                  |                            | 208                | 9.5                        |                 |                                       |                      | USA                            | ,  |
|            | ns 2;   | era              | 11. Marital Status  | 12. Was Decedent  | Ever in U   | .S. 13.                          | Was Deced                  |                    |                            | gin? (Spe       | ecify Yes or No<br>Rican, etc.)       | )~                   | 14. Race - Am                  | erican Indian,                                       |
| (0         | or ital   | Fur              | 1 ☐ Never Married 2 ☐ Marr  | Armed Forces?<br>ied 1 ☐ Yes 2 @  | No          |                                  |                            |                    |                            | , Puerto        | Rican, etc.)                          |                      | Black, Whi                     | te, etc.   |
| 21215-0036 | 72 hours after death with the Maryland<br>natural; or Itams 23e or 28e-f show<br>iteal Examinar must be notified at   | þ                | 3 □XWidowed 4 □ Divorced  | If Yes, Give Year or Dates:   |             |                                  | 1 ☐ Yes                    | 2LINO              | Specify:                   |                 |                                       |                      | Specify: Wh                    | nite   |
| 2-0        | 72 ho   | Completed        | 15. Deceden<br>(Specify only highe  | t's Education   |             | 16a. Dece                        | dent's Usua                | d Occupa           | ation                      | t of worki      | na                                    | 16b. Ki              | nd of Business                 | /Industry  |
| 2          | within<br>ene.<br>than "  | npldu            | Elementary/Secondary (0-12)   | College (1-4or  | 5+)         | life.                            | kind of wo<br>DO NOT us    | e retired          | )                          |                 | 9                                     |                      |                                |  |
|            | filed w<br>Hygier<br>thar th  | Co               | 12  |   |             | Leg                              | al Se                      | cret               |                            |                 |                                       |                      | aw                             |  |
| pu         | S should be filed with<br>and Mental Hygiene,<br>is markad othar that<br>aumatic evant, the M   | Be               | 17. Father's Name (First, Middle,   | ·   |             |                                  |                            |                    |                            |                 | (First, Middle                        |                      | ,                              |  |
| <u>y</u>   | should be<br>ind Mental<br>s markad o<br>umatic eve   | 2                | Edward T. For   |   |             | -                                |                            |                    |                            |                 | nce Mit                               |                      |                                |  |
| Maryland   | 12 sh<br>and<br>ris m   |                  | 19a. Informant's Name/Relations Jane E. Gofor   |   | -           |                                  |                            |                    |                            |                 |                                       |                      | Town, State.                   | Zip Code)<br>DC 20009                                |
|            | s I and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or flams 23a or 28a-f show then 27 is marked other than "natural", or flams and the notified at |                  | 20a. Method of Disposition  |   |             | Place of Dispo                   |                            |                    | ., 1999,                   |                 | ate · · · · ·                         |                      |                                |  |
| Baltimore, | 0 0   |                  | 1 Burial 2 Cremation  |   | 0           | emetery, cre                     | matory`or o                | ther plac          | 1                          | July            | _                                     | 20C. LO              | cation - City or               | Town, State  |
| Ξ̈́        | permit. Pag<br>Department<br>Important: i<br>any injury o   |                  | `4 □ Donation 5 □ Other (S  |   | Me          | tropolit                         |                            |                    | - '                        | 200             | 06                                    |                      |                                | Virginia   |
| 3al        | permit. Departr importa any inje  |                  | 21. Signature of Funeral Service  | Licensee  |             |                                  |                            |                    |                            |                 |                                       |                      | me Inc.                        |  |
|            | 0.01 = 48 OI  |                  | mohen   | from  |             |                                  |                            |                    |                            |                 |                                       |                      | r Sprin                        | g,MD 20901   |
|            | Physician   |                  | 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) | only one cause on each li   | ne.         | n. Do not en                     | ter the mod                | e ot dyln          | g, such as                 | cardiac d       | or respiratory a                      | rrest.               |                                | Approximate Interval Between Onset and Death  1 Week |
|            | /Medical<br>Examiner  | Ġ                | resulting in death)   | Due to (or as   | a conseq    | juence of):                      |                            |                    |                            |                 |                                       |                      |                                |  |
| h,         | pe pe pe  | lner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                     | b. — Due to (or as  | a conseq    | uence of):                       |                            |                    |                            |                 |                                       | _                    |                                |  |
| 90,        | death certificate be executed<br>e attending physician and<br>od for use as the bunal-transit   | I Examiner       | that initiated events<br>resulting in death) Last   | c<br>Due to (or as  | a conseq    | uence of):                       |                            | <u> </u>           |                            |                 |                                       |                      |                                |  |
| 8760,      | cate b  | edlcal           |   | d   |             |                                  |                            |                    |                            |                 |                                       |                      |                                |  |
| 9 ×        | ding p  | /Me              | IF FEMALE:  | 23c. If yes, outcome  | of pream    | ancy                             |                            |                    |                            |                 |                                       |                      |                                |  |
| Вох        | death certifica<br>attending ph<br>for use as th  | Physician/M      | 23b. Was decedent pregnant in the past 12 months?   | 1 Live birth  | 2 🗆 Feta    | ıl déath 3[                      | ☐Ectopic pr<br>☐ Other (sp |                    |                            |                 |                                       | 2                    | 23d. Date of de<br>Month       | livery<br>Day Year                                   |
|            | the de  | ysic             | 1 ☐ Yes 2X No<br>9 ☐ Unknown  | 9□ Unknown  | t time or o | ieaui St                         | _ Other (sp                | өспу)              |                            |                 |                                       |                      |                                |  |
| P.0        | law requires that the death<br>as been signed by the atter<br>2 should be detached for u  |                  | Part II. Other significant condition  | ons contributing to death t   | out not res | ulting in the u                  | inderlying c               | ause give          | en in Part I.              |                 | 23e. Did t                            | obacco u             | se contribute t                | o the cause of death?                                |
| Records,   | uires<br>sign<br>id be  | d by             | Domontia  |   |             |                                  |                            |                    |                            |                 | 10                                    | Yes 2                | QNo 3□P                        | robably 4 Unknown                                    |
| Ö          | w requir<br>been si<br>should   | Completed        | Dementia  |   |             |                                  |                            |                    |                            |                 | 24a. Was                              |                      | Odb Word o                     | utana findina available                              |
| Re         | The lav   | mp               |   |   |             |                                  |                            |                    |                            |                 | auto                                  |                      | prior to death?                | utopsy findings available<br>completion of cause of  |
| a          | ician: Th<br>certificate<br>rector, pag   | e Co             | OF Man and referred to medica   |   |             |                                  |                            |                    |                            |                 | 1 ☐ Yes                               |                      | 1 ☐ Yes                        | s 2□No   |
| Vital      |   | 00               | 25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No  | Hospital:   | ont 2       | ER/Outpatie                      |                            | Othe               | ) F                        |                 | (Check only                           |                      | . Con 12                       |  |
| of         | Fa Fa   | . To             | 27. Manner of Death   | 28a. Date of Inju   | ıry         | 28b. Time o                      |                            | 8c. Injury<br>Work | 4 (X) 140                  |                 | 11e 5 ∐ Hesi<br>28d. Describe         |                      | Other (Spe                     | ocity)   |
| Division   | Attanding Ph<br>r death.<br>actor: After th<br>by the funeral   | Certification:   | 1X Natural 5 ☐ Pendir<br>2 ☐ Accident investi   |   | y Year)     | Injury                           | м                          |                    | <br Yes 2 □!               | No              |                                       |                      |                                |  |
| /isi       |   | fica             | 3 ☐ Suicide 6 ☐ Could   | not be 28e. Place of In   | jury - At h | ome, farm, st                    | reet, factor               | , office           |                            |                 |                                       |                      |                                | ural Route Number,                                   |
| D.         | after<br>Dirac  | erti             | 4 Homicide  | building, e   | tc. (Specil | (y)                              |                            |                    |                            |                 | City or To                            | wn, State,           |                                |  |
|            | Hospita<br>14 hours<br>Funarai<br>tely fillec   | edical C         | 29a. Certifier 1 X Certifyin (Check only one) 2 Medical   | ng Physician: To the best<br>Examiner: On the basis of<br>and manner st | of examina  | owledge, deat<br>ation and/or in | h occurred<br>vestigation  | at the tim         | ne, date an<br>pinion, dea | d place, a      | and due to the<br>ed at the time.     | cause(s)<br>date and | and manner a<br>place, and due | s stated.<br>e to the cause(s)                       |
|            | To the within 2 To the comple   | Mec              | 29b. Signature and title of certifie  |   | and.        |                                  | 290                        | . License          | number                     |                 | · · · · · · · · · · · · · · · · · · · | 29d, Date            | e signed (Mon                  | th, Day, Year)                                       |
|            | 5 × 5 0 0   |                  | )   | 0   |             | 2                                |                            |                    | 528                        |                 |                                       | ~                    |                                | y 5, 2006  |
|            | 4   |                  | 20 Name of 1  | who completed cause of  | doub /lic   | n 230/ (T                        | Print'                     |                    |                            |                 |                                       |                      |                                |  |
|            |   |                  | 30. Name and address of person Daphna Henkin,   |   |             | , , .                            |                            | . Wh               | eator                      | а. Мг           | 20902                                 |                      |                                |  |
|            | Sta   | ate              | 31. Date filed (Month, Day, Year,   |   |             |                                  |                            | 7 111              |                            | -, 111          | 20302                                 |                      |                                |  |
| ***        | Regist  |                  | JUL 06  | 2006  | es d        | ture do                          | and I                      |                    |                            |                 |                                       |                      |                                |  |

|                                 |   | Ľ              | State of Maryland / Depart   | rtment of Health and M<br>tificate of Death   | lental Hygier                                     | 711116  | 22795   |
|---------------------------------|---|----------------|--|---|---|---|---|
|                                 | Physici   | an             | Registrar  1. Decedent's Name (First, Middle, Last)  | modelo oi bodiii  | 2. Date of Death                                  | Day Year,                                     | 3. Time of Death  |
| •                               | /Medic<br>Examin  | al             | Memorial Hospital at Easton  | 4b. City, Town, or Location of Death  |   | 1 2006<br>4c. County of Death<br>1 0-1 50     | +   |
|                                 | Funeral Director  |                | 216-14-3989 <sup>1</sup> □ x M 2□ F 86 Yrs.  | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Yea<br>Jan. 15,1 | 000   | lace (State or Foreign<br>try)<br>y land                |
|                                 | aryland<br>ehow   | -              | Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Local           MD         Caroline  | ation Preston   |   | 1   | 0d. Inside City Limits 1 ☐ Yes 2 ☑ No                   |
|                                 | th the Marylar<br>or 28a-f ehow<br>s notilised at   | Director       | 10e. Street and Number   | 10f. Zip Code   |   | Citizen of What Cour                          | itry?   |
| -                               | eme 23a   | Funeral [      | 3428 Linchester Road  11. Marital Status   | 21655  Vas Decedent of Hispanic Origin? (Spe<br>Yes, specify Cuban, Mexican, Puerto I                 |   | ted Stat                                      | an Indian,  |
| har 5-0036                      | ours after<br>rei', or its  | by             | 1 Never Married 2 TV Married 1 □ Yes 2 No  | ☐ Yes 2 ANO Specity:  | ,   |   | nite  |
| ich,                            | within 72 hours after death with the Maryland<br>ene.<br>than "naturel", or iteme 23e or 28e-1 ehow<br>the Modical Examinar mast be notitied at                                       | Completed      | (Specify only highest grade completed) (Give kife. Di  | ent's Usual Occupation<br>und of work done during most of work!!<br>O NOT use retired)<br>Dody Worker | ng  | Kind of Business/Ind                          |   |
| land 2                          | be filed<br>ntal Hygi<br>od other   | Be             | 17. Father's Name (First, Middle, Last)  Edward Paul Gadow   | 18. Mother's Name   | (First, Middle, Maid<br>1utschak                  |   |   |
| رك «<br>Maryl                   | £ E E   | 오              | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing  | Address (Street and Number or Rura<br>Linchester Rd   | -   |   |   |
| ack                             | Pages 1 and<br>nent of Health<br>int: If Item 27<br>iry or other to   |                | 20a. Method of Disposition  1  | ition (Name of atory or other place)  |   | Location - City or To                         | wn, State   |
| Saltimore                       | permit. Pages 1 and 2 Department of Health a important: if Item 27 is eny injury or other tra   |                | 21. Signature of Funeral Service Licensee 22.  | Name and Address of FacilityFra 6 N. Main St., Fe   | mptom Fu  | neral Ho                                      | ome, P.A.   |
|                                 | Physician   |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final   | 1.1   | or respiratory arrest,                            |   | Approximate<br>Interval Between<br>Onset and Death      |
|                                 | /Medical<br>Examiner  |                | disease or condition resulting in death)  Due to (or as a consequence of):   | - Heart to  | entis   |   |   |
| ó                               | rate be executed hysicien and the burial-transit  | Examiner       | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  |   |   |   |   |
| 68760,                          | the the   | ledical        | d  |   |   |   |   |
| .O. Box 6                       |   | Physician/Me   |  | Ectopic pregnancy<br>Other (specify)  |   | 23d. Date of delive<br>Month                  | ny<br>Day Year  |
| rds, P                          | quires that<br>in signed b  | Ď              | Part II. Other significant conditions contributing to death but not resulting in the unc   | derlying cause given in Part I.   |   | o use contribute to the                       |   |
| Division of Vital Records, P.O. | The law requir<br>ate has been s<br>page 2 should   | Completed      |  |   | 24a. Was an autopsy performed? 1 □ Yes 2 ℚ        | death?  | psy findings available<br>inpletion of cause of<br>2 No |
| Vita                            | tician: Th<br>certificate<br>rector, pag  | Be             | 25 Was case referred to medical examiner?  Hospital:   | 26. Place of Death  |   |   |   |
| on of                           | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | itlon: To      | 27. Manner of Death 1 Natural 5 Pending 2 Accident   Ac | 3 DOA 4 Tradising flor  | me 5 Residence<br>28d. Describe how in            |   | /)  |
| Divísi                          | To the Hospital or Attending P<br>Within 24 hours after death.<br>To the Funeral Director: After<br>completely filled in by the funera  | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)   | et, factory, office   | 28f. Location (Street<br>City or Town, Sta        | and Number or Rura<br>ate)                    | I Route Number,   |
|                                 | Hospitu     24 hours     Funeral  | Medical C      | 29a. Certifier (Check only one)  Check only one)  Check only one)  Check only one)  Check only one one of the basis of examination and/or investance and manner stated.  | occurred at the time, date and place, a estigation, in my opinion, death occurr                       | and due to the cause<br>ed at the time, date a    | (s) and manner as si<br>and place, and due to | ated.<br>the cause(s)                                   |
|                                 | To th<br>To th<br>comp  | Me             | 29b. Signature and title of certifier  | 29c. License number   |   | Date signed (Month,                           |   |
|                                 |   |                | 30. Name and address of person who completed cause of death (Item 23a) (Type, P  | Print)  | 33771   |   | 2006  |
|                                 | Ale Sta   | ate            | Dennis M. DeShields, MD 219 S. Wash: 31. Date filed (Month, Day, Year) 32. Registrar's Signature   | ington St., Easton  | n, MD 2160  | )1  |   |
|                                 | Regist  |                | 1 2 2000   | 1   |   |   |   |

State of Maryland / Department of Health and Mental Hygiene 2006 22796

|                            |  |                     |  | Cen           | ilicate of                            | Dealli                  |                                       | Reg. No.            |  |
|----------------------------|--|---------------------|--|---------------|---------------------------------------|-------------------------|---------------------------------------|---------------------|--|
|                            |  |                     | Decedent's Name (First, Middle, Last)  |               |                                       |                         | 2. Date of De<br>Month                |                     | 3. Time of Death                       |
|                            | Physici  |                     | Merle Everett Gay  |               |                                       |                         |                                       | 11, 200             | 6 2:09 PM                              |
| , e                        | /Medic   |                     | 4a Facility Name (If not institution, give street and number)  |               |                                       | 4b. City, Town, or      | Location of Deat                      |                     | <u> </u>                               |
| A PART                     | Examir   | iei                 |  |               |                                       | TT:::                   |                                       |                     |  |
|                            |  |                     | Julia Manor Health Care Center   |               | Milledge 4 Vees                       | Hagers                  | cown                                  | Washi               | ngton                                  |
|                            | Funeral  |                     | 5. Social Security Number 6. Sex 7. Age (In yrs. last  | birthday)     | Months Days                           | Hours Mir               | S. 8. Date of Bir<br>(Month, Da       | th<br>ly, Year)     | Birthplace (State or Foreign Country)  |
|                            | Director   |                     | 230-02-0733 ^ 64   | Yrs.          |                                       |                         | \$eptemb                              | er 2, 19            |  |
|                            | D  |                     | Usual Residence of Decedent  |               |                                       |                         |                                       |                     |  |
|                            | yler<br>how  |                     | 10a. State 10b. County 10c. City, To   | own or Loca   | ation                                 |                         |                                       |                     | 10d. Inside City Limits                |
|                            | N T  | ō                   | Maryland Washington Ha   | gers          | town                                  |                         |                                       |                     | Yes 2□No                               |
|                            | \$ 25 E  | ည                   | 10e. Street and Number   | 3             | 10f. Zip Code                         | -                       |                                       | 10g. Citizen of W   | hat Country?                           |
|                            | Air A  | ō                   | 333 Mill Street  |               | 21740                                 | <b>1</b>                |                                       | U.S.                |  |
|                            | # 23   | era.                |  | 40.34         |                                       |                         | 0                                     |                     |  |
|                            | be filad within 72 hours aftar deeth with the Merylend tiel Hygiene. Id other than "natural", or items 23s or 23s-f show event, the Medical Examiner must be notified at   | Funeral Director    | 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?   | 13. W         | as Decedent of F<br>res, specify Cuba | an, Mexican, Pue        | Specify Yes or No<br>nto Rican, etc.) | Black               | - American Indian,<br>, White, etc.    |
| റ്റ .                      | a o  |                     | 1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No If Yes, Give  | 1[            | JYes 2XNo                             | Specify:                |                                       | Specify:            |  |
| ğ                          | ours   | 1 by                | 3 ☐ Widowed 4 ☐ Divorced Year or Dates:  |               |                                       |                         |                                       | oposity.            | White                                  |
| 2                          | 72 h   | Completed           | 15. Decedent's Education (Specify only highest grade completed)  | 6a. Decede    | nt's Usual Occup                      | nation                  | nkina                                 | 16b. Kind of Bus    | siness/Industry                        |
| 7                          | within ene.  | 호                   | Elementary/Secondary (0-12) College (1-4or 5+)   | life. Do      | NOT use retired                       | during most of wo<br>d) | ,g                                    |                     |  |
| 7                          | I THE STATE OF THE | 6                   | 9  | L             | aborer                                |                         |                                       | Const               | ruction                                |
| D                          | 事事   | 0                   | 17. Father's Name (First, Middle, Last)  |               |                                       | 18. Mother's Na         | me (First, Middle                     | Maiden Sumame       | )                                      |
| an                         | ad be  | Be                  | Marvin Daniel Gay  |               |                                       | Nina                    | 01.                                   | ndola               | Ma Carran                              |
| 5                          | should be filad<br>nd Mentel Hygi<br>marked other<br>imatic event, I   | ၉                   | _  |               |                                       |                         |                                       |                     | Mc Gowan                               |
| Maryland 21215-0020        | 2 st<br>ence<br>is n   |                     |  | _             |                                       |                         |                                       | ər, City or Town, S |  |
|                            | end<br>salth   |                     | Marlene L. Gay Wife  | 817 Da        | ale Stre                              | et, Hage                | erstown,                              | Maryland            | 21740                                  |
| 5                          | of Ten   |                     | 20a. Method of Disposition 20b. Place  | of Disposi    | tion (Name of<br>tory or other plac   |                         | Data                                  | 200 Location C      | Shr or Town Ctate                      |
| Ĕ                          | ege<br>ant c<br>y or   |                     | 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smit   | helou         | ro Crer                               | natory                  | AGTATO                                | Smithsh             | urg, Md.                               |
| Baltimore,                 | permit. Peges 1 and 2 should be<br>Department of Health and Mente<br>Important: if Itam 27 is marked<br>any injury or other traumatic ex<br>ance.  |                     | 21. Signature of Funeral Service Licensee  | -             |                                       |                         |                                       |                     |  |
| Ba                         | Depa<br>Impo   |                     | 21. Signature of Pulleral Service Licensee   | 7 T           |                                       | ssoraciny               |                                       | 12525               | Bradbury Ave sburg, Md.                |
|                            | 40 = 6 G   |                     | John Davis Mo141   | 4             | L. Dav.                               | is rune                 | ral Ho                                | mesmith             | 21723                                  |
|                            |  |                     | 29a. Part . Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.  | o not enter   | the mode of dyir                      | ng, such as cardia      | c or respiratory a                    | rrest,              | Approximate                            |
| No.                        | Physician  |                     | snock, or near failure. List only one cause on each line.  |               |                                       |                         |                                       |                     | Interval Between<br>Onset and Death    |
| 1                          | /Medical   |                     | Immediate Cause (Final   | ~ /           | 1 1-                                  | - 0.1                   |                                       | 1                   |  |
|                            | Examiner   |                     | disease or condition resulting in death) a. Wivinue  | OV            | svate                                 | wan                     | way o                                 | Useare              | 54ears.                                |
|                            |  | <u>.</u>            | Due to (or as  | a conseque    | ence of):                             |                         | ()                                    |                     |  |
|                            | D #  | an/Medical Examiner | Immediate Cause (Final disease or condition resulting in death)  a. Chivme Due to (or as   | lout          | u con                                 | dio- vi                 | scular                                | - desia             | u 6 Months.                            |
|                            | The law requires that the death certificate be assocuted ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit  | am                  | Sequentially list conditions, Due to (or as  | a conseque    | ence of):                             |                         |                                       |                     |  |
| ó                          | axe<br>en a  | m                   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  |               |                                       |                         |                                       |                     |  |
| ox 68760,                  | s be<br>sici   | cal                 | that initiated events  | a conseque    | nce of):                              |                         |                                       |                     |  |
| 89                         | ficat<br>phy<br>s th   | 장                   | resulting in death) Last   | a consoque    | 1100 017.                             |                         |                                       |                     |  |
| ×                          | ding<br>ding<br>se e   | 3                   | d  |               |                                       |                         |                                       |                     |  |
| മ                          | ath  | a                   |  |               |                                       |                         |                                       |                     |  |
|                            | s de   | Physicia            | Part II. Other significant conditions contributing to death but not resulting  | in the und    | erlying cause giv                     | en in Part I.           | 23b. Did                              | obacco use cont     | ribute to the cause of death?          |
| P.<br>0.                   | by t   | 5                   |  |               |                                       |                         | 100                                   | Yes 2□No            | 3 Probably 4 Unknown                   |
|                            | s the  | P<br>P              |  |               |                                       |                         |                                       |                     |  |
| ë                          | n sig  | ᇴ                   |  |               |                                       |                         | 24a. Was                              |                     | 24b. Were autopsy findings             |
| 8                          | bee<br>shor  | e                   |  |               |                                       |                         | perfo                                 | med?                | available prior to completion of cause |
| ĕ                          | has<br>e 2   |                     |  |               |                                       |                         |                                       | 5.                  | of death?                              |
| =                          | The gata   | Completed           |  |               |                                       |                         | 101                                   | res 200 No          | 1 ☐ Yes 2 ☐ No                         |
| Ħ                          | lan:<br>rtific<br>ctor,  | Be                  | 25. Was case referred to medical examiner?   |               |                                       | 26. Place of De         | ath (Check only o                     | ne)                 |  |
| 2                          | yaic<br>s ce<br>dire   | 2                   | — Hospital:  | Outpatient    | 3□ DOA Oth                            | er: 45 Nursing I        | Home 5 ☐ Resid                        | dence 6 □Other      | (Specify)                              |
| 0                          | Ph<br>eral   |                     |  | . Time of     | 28c. Injur                            |                         |                                       | now injury occurre  |  |
| 5                          | After After  | 후                   | in a still s | Injury        |                                       | k?<br>Yes 2 □ No        |                                       |                     |  |
| Division of Vital Records, | deat<br>deat<br>tor:<br>/ tha  | Certification:      | 3 Suicide 6 Could not be   | form etroe    |                                       |                         | 29f Location /                        | Stroot and Number   | r or Rural Route Number,               |
| <u>≥</u>                   | frer<br>frec<br>n by   | ŧ                   | 4 Homicide determined building, etc. (Specify)   | iairii, Stiee | t, ractory, office                    |                         | City or Tox                           |                     | or nural noute Number,                 |
|                            | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2  | ပ္                  |  |               |                                       |                         |                                       |                     |  |
|                            | hor nily fil   | edicai              | 29a. Certifier Certifying Physician: To the best of my knowled Check only 2 Medical Examiner: On the basis of examination a  | ge, death o   | ccurred at the tin                    | ne, date and place      | and due to the                        | cause(s) and man    | ner as stated.                         |
|                            | n 24<br>n 24<br>ne Fi  | <u>8</u>            | one) and manner stated.  | and of HIVE:  | nigation, in my 0                     | pinion, death occi      | andu at the time,                     | uate and place, an  | id due to the cause(s)                 |
| _                          | Nithi<br>Foth  | Σ                   | 29b. Signature and title of certifier  | _             | 29c. Licens                           | e number                |                                       | 29d. Date signed    | (Month, Day, Year)                     |
|                            |  |                     | May san 9 Mral   |               | D 2                                   | 8365                    |                                       | 7 11 2              | 4                                      |
|                            |  | -                   |  |               | 1                                     | 0 /03                   |                                       | 1-11-0              | 0,                                     |
|                            | 2  |                     | 30. Name and address of person who completed cause of death (Item 23a  | a) (Type, Pr  | int)                                  | .1                      | 11-0                                  | 0 1000              | 2 1/2                                  |
|                            | V  |                     | 17 HN ZAIL DSNUAJUI  | 368           | nul                                   | Hrall.                  | Herys                                 | tan M               | 6.                                     |
|                            | Sta  | te                  | 31. Date filed (Month, Day, Year) 32 Jegistrar's Signature   |               | Ten                                   |                         | ,                                     |                     |  |
|                            | Registr  | ar                  | JUL 2 0 2006 R   | Mag           | chi a                                 |                         |                                       |                     |  |

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 115 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 630AM <sup>M</sup> Lilyan Caroline Hoare 07 80 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genesis - The Pines Easton, Talbot Maryland
If Under 24 Hrs. 8, Da 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New Jersey **Funeral** Days Hours 93 212-66-1668 1912 Director Dec. 28, New Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Yes 2 No Caroline Preston Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21655 United States of America Apt. 1 6367 Harmony Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. an "netural", or Items Medical Examiner on 11. Marital Status 1 □Yes 2√2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Telerica Mango Pasquale Bruno 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 26562 Burrsville Road, Denton, Maryland 21629 Son Kenneth Moore 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place 1 ☐ Burial 2 ☐ Cremation 3. ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) New 7/14/2006 Cinnaminson, Terseu Park Cometery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Marykand 21629 23a. Part1. En er the disease or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Manual S caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) brown scular acciden Physician /Medical **Examiner** GERS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year 5 Other (specify) been signed by the should be detached 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 5 Pending investigation within 24 hours after deau...

To the Funerel Director: At 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of yearh (Item 23a) (Type, Print) -doe Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

|          |  |             | For State Registrar  | State of M                                     | *  |                 |                      |                 | ind Me          |                                | 20                                      | 06                    | 22              | 798                  |
|----------|--|-------------|--|--|--|-----------------|----------------------|-----------------|-----------------|--------------------------------|---|-----------------------|-----------------|----------------------|
|          | Physicia   | an          | 1. Decedent's Name (First, Middle  | , Last)  |  |                 |                      |                 |                 | Month                          | Day                                     | Year                  |                 |                      |
|          | /Medic   | al          |  |  | ar)  | 4h              | City Town or         | Location o      |                 | JULY 1,                        |   | of Death              |                 | A™                   |
|          | Examin   | er          |  |  | ,  |                 |                      |                 |                 |                                | 1                                       |                       |                 |                      |
|          | Physician Model   Construct Number   Price Medicine   Construct Number   Price Medicine   Construct Number   Price Medicine   Construct Number   Price Medicine   Construct Number   Price Medicine   Construct Number   Price Medicine   Construct Number   Const |             | r Foreign  |  |  |                 |                      |                 |                 |                                |   |                       |                 |                      |
|          | Description of Section of Chart   Control of Char |             |  |  |  |                 |                      |                 |                 |                                |   |                       |                 |                      |
|          | land<br>ow   |             |  |  | 10c. City, Town  | or Locatio      | n                    |                 |                 | -                              |   | 1                     | 10d. Inside Ci  | ty Limits            |
|          | e-feh  | ctor        | MARYLAND MONTGOI   | MERY   | OLNEY  |                 |                      |                 |                 |                                |   |                       | 1 🗆 Yes         | 2 📉 No               |
|          | ith th   | Dire        | 10e. Street and Number   |  |  | 10              | Of. Zip Code         |                 |                 | 1                              |   | What Cou              | ntry?           |                      |
|          | eath v   | eral        |  |  | nt Ever in U.S.  | 13 Was I        |                      | snanic Orio     | nin? (Spec      | ify Yes or No-                 |   | e - Americ            | can Indian      |                      |
| 36       | irs after d  | by Fun      | 1 Never Married 2 X Marr   | Armed Force<br>ied 1 X Yes 2 [<br>If Yes, Give | s?<br>⊒No  | If Yes          | s, specify Cubar     | n, Mexican      | , Puerto R      | ican, etc.)                    | Bla                                     | ck, White,            | etc.            |                      |
| ဝို      | 72 hou   |             |  |  | 16a. E   |                 |                      |                 | of working      | 7                              | 16b. Kind of B                          | usiness/In            | dustry          |                      |
| 21       | nithin 7<br>ne.  | mple        | Elementary/Secondary (0-12)  |  | or 5+)   | life. DO N      | IOT use retired)     | )               | OI WOMING       |                                | DITIMDING                               |                       |                 |                      |
| 2        | Hygiei<br>Hygiei<br>therti   |             |  | Last)  | MA   | SIER P          |                      | 18. Mothe       | r's Name (      |                                |   | ne)                   |                 |                      |
| lan      | id be<br>ental<br>ked o<br>ic eve  | o Be        |  |  |  |                 |                      |                 |                 |                                |   |                       |                 |                      |
| ary      | shou<br>and M<br>mar   | -           |  |  | 19b.   | Mailing Ad      | idress (Street a     | nd Numbe        | r or Rural      | Route Numbe                    | r, City or Town,                        | State, Zip            | Code)           |                      |
| Σ        | and 2<br>ealth<br>m 27 i   |             |  | USE  | The same of the sa | THE DESCRIPTION |                      | RIVE,           |                 | -                              |   | 011                   |                 |                      |
| lore     | if it of H or of or oth  |             | 1   Burial 2 □ Cremation   |  | te cemetery  | , cremator      | y or other place     | 1               |                 |                                |   |                       |                 |                      |
| Ħ        | iit. Pa<br>artmer<br>ortent<br>injury<br>i.  |             |  |  | NORBECK  | 1               |                      |                 |                 | 2006                           | DLNEY, MA                               | RYLANI                | J .             |                      |
| Ba       | Deported Park  |             | • amanda   | Luder  | urg  | HINES<br>11800  | S-RINALDI<br>NEW HAM | FUNER<br>PSHIRE | AL HOM<br>AVENU | E, SILVE                       |   | , MARY                |                 |                      |
| 8760,    | /Medical<br>Examiner   |             | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | a Due to (or b Due to (or c                    | as a consequence of  | c teel          | roung                | EM              | t o             | ane (c                         | ge Pels                                 | to                    | Onset and I     | res                  |
| Box 6    | the death certify the attending ched for use a:  | yslclan/Med | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No   | 1□Live birth<br>4□Pregnan                      | 2 Fetal death<br>t at time of death  |                 |                      |                 |                 |                                |   |                       | ,               | /ear                 |
| <u>α</u> | quires that<br>in signed b<br>uld be deta  | þ           | Part II. Other significant condition   | ons contributing to deat                       | h but not resulting in   | the underl      | lying cause give     | on in Part I.   |                 | 23e. Did to                    | bacco use con<br>es 2 No                |                       |                 |                      |
| Reco     | The<br>ate h<br>page   | Complet     |  |  | ·  |                 |                      |                 |                 | autop:<br>perfor               | ned?                                    | prior to co<br>death? | impletion of ca | available<br>ause of |
| Vita     | icien:<br>Sertific<br>ector.   | Be          |  | . /  |  |                 | Otho                 | 200             |                 |                                |   |                       |                 |                      |
| of       | Phys<br>this<br>aldi   |             |  | 28a. Date of I                                 | njury 28b. Ti  |                 | DOA                  | 4 190           |                 |                                |   |                       | fy)             |                      |
| ion      | nding<br>th.<br>r: Afte<br>e fune  | ation       | 1⊠Natural 5 ☐ Pendir   | ng (Month,                                     | <i>Day Year)</i> In  |                 |                      |                 |                 |                                | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                       |                 |                      |
| Divis    | el or Atters after des l'Director  | Sertifica   | 3 ☐ Suicide 6 ☐ Could  | uned 288. Place of                             | Injury - At home, fare, etc. (Specify)   | m, street, i    | factory, office      |                 | 28              | 3f. Location (S<br>City or Tow | treet and Numl<br>n, State)             | per or Rura           | al Route Num    | ber,                 |
|          | Hospit.<br>24 hours<br>Funere<br>letely fille  |             | (Check only 2 Medical  | Examinar: On the basi                          | s of examination and   |                 |                      |                 |                 |                                |   |                       |                 | )                    |
|          | To th<br>To th<br>comp   | Me          | 29b. Signature and title of certifie   | B/   | 1/4/1  | 11/             | 29c License          | number          | 0/              | 2                              | od. Date signe                          | d (Month,             | Day, Year)      |                      |
|          | 12   |             | Momo   | 0114   | Solly 1  | NV              | 1/14                 | 195             | Y               | - 1                            | ake                                     | 2,0                   | 100             | -                    |
|          | •  | -           |  | o completed cause of                           | of death ( 23a) (1   | Type, Print     |                      | Aine            | ue. E           | wind                           | y in                                    | Dala                  | woll Art        | <b>3</b>             |
| 10       | Sta<br>Regist  | ate<br>rar  | 31. Date filed (Month, Day, Year,  | 2006 Reg                                       | istrar's Signature   | borte           | )                    | שועון           | -) (            | 1                              |   | - July                |                 |                      |
| 300      |  | - 6         | 002 00   | THE PERSON                                     | ~ /- /-/   |                 |                      |                 |                 |                                |   |                       |                 |                      |

|            |                            |  |                | 1 - For Amend #12&20b  | Stater Mai   | ryland/I                       | Department of H<br>9725706 JH<br>Certificate of                                | lealth and Me<br><i>Death</i>                       | ntal Hygie<br>Reg.                            | ne 2 0 0 6                                    | 22799   |
|------------|----------------------------|--|----------------|--|--|--------------------------------|--|---|---|---|---|
|            |                            |  | 4              | 1. Decedent's Name (First, Middle, Las   | st)  |                                |  |   | . Date of Death                               |   | 3. Time of Death                                |
| _          |                            | Physici<br>/Medic  |                | Barry L  | · Johns  | un                             |  |   |   | Day Year                                      | 2100 M  |
|            |                            | Examin   |                | 4a. Facility Name (If not institution, give  |  |                                | 4b. City, Town, o  | r Location of Death                                 |   | 4c. County of Death                           |   |
|            |                            |  |                | Atlantic General I   | Hospital   |                                | Berli  | n   |   | Worce   | ster  |
|            | -                          | Funeral  |                | 5. Social Security Number 6. S   | ex 7. Age  | (In yrs. last bii              | rthday) If Under 1 Year<br>Months Days   | If Under 24 Hrs. 8.                                 | Date of Birth                                 | 9. Birth                                      | place (State or Foreign                         |
|            |                            | Director   |                | 220-52-0798  | <b>™</b> M 2□ F  | 55                             | Yrs. Months Days   | Tours Mill.   | Date of Birth<br>(Month, Day, Ye<br>) ec. 18, | 1950 Mar                                      | ÿľand   |
|            |                            | P.   |                | Usual Residence of Decedent  |  | 10- Oh T                       |  |   |   |   |   |
|            |                            | aryla:   | _              | 10a. State 10b. County   |  | 10c. City, Tow                 | m or Location  |   |   |   | 10d. Inside City Limits 1 ☐ Yes 2 X No          |
|            |                            | Be-f   | cto            | Maryland   Worceste  | er   | Bishop                         |  |   |   |   |   |
|            |                            | ith th   | Director       | 10e. Street and Number   |  |                                | 10f. Zip Code  |   | 10g.  | Citizen of What Cou                           | ntry?   |
|            |                            | death with the Maryland<br>ms 23s or 28e-f show  | Ta.            | Old Stage Road   |  |                                | 218  |   |   | USA   |   |
|            |                            | tems   | Funeral        | 11. Marital Status   | 12. Was Decedent Ev<br>Armed Forces?<br>1-XIYes XX No  | er in U.S.                     | <ol> <li>Was Decedent of I<br/>If Yes, specify Cub</li> </ol>                  | lispanic Origin? (Specif<br>an, Mexican, Puerto Ric | y Yes or No-<br>can, etc.)                    | 14. Race - Ameri<br>Black, White,             |   |
| 3          | 36                         | 72 hours after<br>natural', or Ite   | by F           | 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced                             | If Yes, Give I J   | <del>'71</del>                 | 1 ☐ Yes 2 🛣 No   | Specify:  |   | Specify: Dla                                  | ole   |
| 0.00       | 5-0036                     | hour<br>tural  |                | 15. Decedent's Ed  | Year or Dates:   | 160                            | Decedent's House Coope   | ation   | 101   | Bla   |   |
| Ü          | 7.                         | "nai   | Completed      | (Specify only highest gra  |  | 104                            | . Decedent's Usual Occup<br>(Give kind of work done<br>life. DO NOT use retire | during most of working                              | 100   | b. Kind of Business/In                        | dustry  |
| 000        | 2121                       | within<br>lene.<br>then "  | m/             | Elementary/Secondary (0-12)<br>12th  | College (1-4or 5+)   | ) _                            | aborer   | -,  |   | Odd Jobs                                      |   |
| SO         | 2                          | filled<br>Hygi<br>ether  | Ö              | 17. Father's Name (First, Middle, Last)  |  | 10                             | 150101   | 18. Mother's Name (F                                |   |   |   |
| 2000       | an a                       | d be<br>ontal  | o B            | Grover Lee   | Spencer  |                                |  | Aline   |   | Johnson                                       |   |
| 3 5        | <u>Z</u>                   | should be filed<br>and Mental Hygi<br>Is marked other<br>eumatic event,  | ř              | 19a. Informant's Name/Relationship (   |  | 191                            | o. Mailing Address (Street   |   | Route Number C                                |   |   |
| 2 5        | ະ ຊຶ                       | is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23c or 28e-1 show other treumatic event. It a Modical Exit. Intel intel is could be invilled at |                | Robert Spencer/bro   |  |                                | 345 Downs R  |   |   |   |   |
|            | Baltimore,                 | iges 1 and of He   |                | 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3                              |  | MIsemel                        | of Disposition (Name of Party of Party)  | ce) Cem.  | Sno   | ow Hill, Md                                   |   |
|            | i iii                      | t. Pa<br>rtmen<br>rtent:<br>njury  |                | `4 □Donation 5 □ Other (Specify  |  | HD V                           | 'eteran's Con  |   |   | urlock, Ma                                    |   |
| ~ L        | ر<br>Baا                   | permit. Pages 1 Department of F Importent: If ite eny injury or ot   |                | 21. Signature of Funeral Service Licer   | O. Jolle   | ey                             |  | ess of Facility 1213<br>MEMORIAL (                  |   | Road - Sal                                    | 21801   |
|            | -                          |  |                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only        | plications that caused the   | he death. Do                   | not enter the mode of dyi  | ng, such as cardiac or r                            | espiratory arrest,                            |   | Approximate<br>Interval Between                 |
| 00         |                            | Physician ·  |                | Immediate Cause (Final disease or condition  | 5  | epsis                          |  |   |   |   | Onset and Death                                 |
| 2          |                            | /Medical   |                | resulting in death)  | Due to (or as a  | -                              |  |   |   |   |   |
| 7          |                            | Examiner   |                | Out and the line and the   | h - 510  | LIC C                          | ell crisis   |   |   |   |   |
| 0          |                            |  | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a  | consequence                    |  |   |   |   |   |
| 7          |                            | cuted<br>nd<br>ransit  | Examiner       | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events       | c  |                                |  |   |   |   |   |
| S          | ó                          | ne death certificate be executed<br>the attending physician and<br>hed for use as the burial-transit   |                | resulting in death) Last   | Due to (or as a  | consequence                    | of):   |   |   |   |   |
| 1          | 68760,                     | ate be<br>nysici<br>he bu  | edical         |  | d  |                                |  |   |   |   |   |
| 2          | _                          | ntifica<br>ng pt   | Med            | IF FEMALE:   |  |                                |  |   |   |   |   |
| à          | Вох                        | death certif<br>e attending<br>id for use a  | lan/Me         | 23b. Was decedent pregnant   | 23c. If yes, outcome of<br>1 ☐ Live birth 2  | f pregnancy<br>: ☐ Fetal death | 3 □Ectopic pregnanc  | v   |   | 23d. Date of deliv                            |   |
| _          |                            | dea<br>death   | C              | in the past 12 months? 1 Yes 2 No  | 4☐Pregnant at ti<br>9☐Unknown  |                                | 5 Other (specify)  | ,<br>   |   | Month   | Day Year  |
| L. Johnson | P.0                        | requires that the deben signed by the should be detached   | Physi          | 9 ☐ Unknown  |  |                                |  |   |   |   |   |
| ns         |                            | es th<br>gned<br>be de   | by             | Part II. Other significant conditions of   |  | not resulting i                | in the underlying cause given  | en in Part I.                                       |   | co use contribute to t                        | 4   |
| ch         | ord                        | en si<br>ould  |                | Upper GI   | DICECT   |                                |  |   | 1 🗆 Yes                                       | 2 □ No 3 □ Prot                               | pably 4 Unknown                                 |
| Š          | Division of Vital Records, | law re<br>as be<br>2 sh  | Completed      | •  |  |                                |  |   | 24a. Was an autopsy                           | 24b. Were auto                                | ppsy findings available<br>mpletion of cause of |
|            | R                          | The I  | E              |  |  |                                |  |   | performed                                     | d? death?                                     | 2□ No   |
| *          | ta                         | en:<br>tifica<br>tor, p  | e              | 25. Was case referred to medical   |  |                                |  | 26. Place of Death (0                               |   | 10 100  |   |
| Barry      | >                          | ysici<br>is cer<br>direc   | OB             | examiner?  | Hospital: 1 Inpatient  | t 2 ER/O                       | utpatient 3 DOA Oth  | ner: 4 Nursing Home                                 | 5 Residence                                   | e 6 Other (Special                            | (y)   |
| 30         | ō                          | g Ph<br>er th<br>ieral   | ı.             | 27. Manner of Death  | 28a. Date of Injury<br>(Month, Day   | 28b.                           | Time of 28c. Injury Wo   |   | d. Describe how i                             |   |   |
|            | <u>.</u>                   | ndin<br>ath.<br>r: Aft   | atio           | 1 Natural 5 Pending<br>2 Accident investigation                                    |  | . 01.)                         |  | Yes 2 □No   |   |   |   |
|            | <u>×</u>                   | Atte   | ijic           | 3 ☐ Suicide 6 ☐ Could not be determined  |  |                                | arm, street, factory, office   | 28f   | Location (Stree<br>City or Town, S            | t and Number or Rura                          | al Route Number,                                |
|            |                            | s afte   | Certification: |  | Banding, etc.  | (Spoorly)                      |  |   | J., J. 10411, J                               | /   |   |
|            |                            | To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate has goompletely filled in by the funeral director, page 2   | edical (       | (Check only 2 Medical Exer   | niner: On the basis of e   | examination ar                 | e, death occurred at the ti  | me, date and place, and<br>opinion, death occurred  | d due to the caus<br>at the time, date        | e(s) and manner as s<br>and place, and due to | tated.<br>the cause(s)                          |
|            |                            | vithin 2<br>o the  | Med            | one) 29b. Signature and title of certifier   | and manner state   |                                | 29c. Licens  |   |   | Date signed (Month,                           |   |
|            |                            | (0)  |                | 1 / LIMAN 70   | amound "   | MA                             | Do   | 1051,207  |   | JUN 3.  | 2006  |
|            | ,                          | 260  |                | 30. Name and address of person who   | mond /   | ath (Item 23a)                 | (Type, Print)  | V -U3V+   |   | Cherlin                                       | my  |
|            | 4                          | 711  |                | J. Van Egmond  | mo, A  | + Kan +i                       | (Type, Print) Ceneral It   | moited a  | 133 Her                                       | 11thur 1                                      | Vive 21811                                      |
|            |                            | Sta  | ite            | 31. Date filed (Month, Day, Year)  |  |                                |  | 1   | ,   |   |   |
|            |                            | Regist   |                | JUL 0 6 20   | 06 Mag.  | H.                             | Sports   |   |   |   |   |
|            |                            |  |                |  | Acres de la constante de la co |                                | and and  |   |   |   |   |

Catherine Letteney

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

|  |   | - For State<br>Registrar  |                         |  | Ce                            | ertifica              | ate of i                   | Death                           |           |                        |            |                            | Reg No                 | -20                         | 3 O f                  | 5 2280                     |
|--|---|---|-------------------------|--|-------------------------------|-----------------------|----------------------------|---------------------------------|-----------|------------------------|------------|----------------------------|------------------------|-----------------------------|------------------------|----------------------------|
| Physicia   |   | 1 Decedent's Name (Fire   | st, Middle,Last)        |  | -                             |                       |                            |                                 |           |                        | 2.         | Date of De                 |                        | Voor                        | 3                      | 3. Time of Death           |
| Medical Exami  |   | Catharine   | Poppe L                 | ettene   | у                             |                       |                            |                                 |           |                        |            | Month<br>July 1, 2         | 006                    | Year                        |                        | 2341 hrs                   |
|  |   | 4a. Facility Name (if not i<br>University of Ma   | _                       |  |                               |                       | 41                         | . City, Tow<br>Baltimo          |           | ocation of             | Death      |                            | 40                     | County of                   | Death<br>ne            |                            |
| Funeral  |   | 5 Social Security Number  | er 6. Sex               |  | 7. Age (In yrs                | last birt             | hday)                      | If Under 1                      | Year      | If Under               | 24Hrs.     | 8. Date of E               | Birth (MM              | /DD/YYYY                    | 9. Birthi              | place (State or            |
| Director   | _ L   | 212-52-0473   |                         | M 2 X F  |                               | 55                    | Yrs.                       | Months                          | Days      | Hours                  | Min.       | July                       | 10,                    | 1950                        | Cour                   | Washington<br>D.C.         |
| auv  | -   | Usual Residence of Dece<br>10a State 10b.   | County                  |  | 10c. Ci                       | ty, Town              | or Locatio                 | n                               | _         |                        |            |                            |                        |                             | 1                      | 10d Inside City Limits     |
| * .  | į.  | Maryland M  | ontgome                 | ry   | Ga                            | ithe                  | rsbur                      |                                 |           |                        |            |                            |                        |                             |                        | 1 Yes 2 X No               |
| ith the Mary<br>23a or 28a-<br>notified at   | as I  | 10e. Street and Number $18543$ Cape .   | Jasmine                 | Way  |                               |                       |                            | 10f. Zip Co                     |           |                        |            |                            |                        | ted S                       |                        |                            |
| D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f she ratic event, the Medical Examiner must be notified at once   | Funeral   | 11 Marital Status 1 Never Married   | 2 X Married             | 12. Was Dece<br>Armed Fo                         | rces?                         | US                    |                            | Decedent<br>s, specify (        |           |                        |            | ify Yes or N<br>can, etc.) | <b>1</b> 0-            | 14. Race -<br>White,        |                        | an Indian, Black.          |
| rs after de<br>ural", or   | 2   | 3 Widowed 4  15. Decedent's Educati   |                         | 1 Yes If Yes, Give Year or Dates: y highest grad |                               | 16a. l                |                            | res 2 X                         |           | _                      | and of wor | k done                     | 16b.                   | Specify:<br>Kind of Busi    | Wh i                   |                            |
| 2 hours a<br>"natura   | Completed   | Elementary/Secondary  |                         | College (1                                       |                               |                       |                            | st of working                   |           |                        |            |                            | 115                    |                             |                        | County                     |
| 215-0036<br>be filed within 7<br>med Hygiene<br>rked other than<br>ent, the Medica   |   | -   |                         | 5-   | +                             | :                     | Schoo                      | 1 Tea                           | ache      | r                      |            |                            | Pu                     | blic                        | Scho                   | ools                       |
| 5-0<br>led w<br>Hygie<br>other   | 3   | 17 Father's Name (First   | , Middle, Last)         |  |                               | - n                   |                            |                                 | - 1       |                        | ,          | irst, Middle               | Maider                 | Surname)                    |                        |                            |
| 121<br>lbe fil<br>ental l<br>arked   | a   | William   |                         |  |                               |                       | oppe                       |                                 |           |                        | arin       |                            |                        |                             |                        | Harper                     |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 permit of Health and Mental Hydgene Important: If item 27 is marked other than injury or other traumatic event, the Medical   |   | 19a Informant's Name/R<br>Ronald L. Le  |                         |  |                               | 18                    | 8543                       | Cape                            | Jas       | mine                   | Way        | , Gai                      | ther                   |                             | , MD                   | 20879                      |
| Baltimore, MD bermit Pages I and 2 shu Department of Health and Important: If item 27 is injury or other traumat   |   | 20a Method of Dispositi  1 XBurial 2 C  |                         | Removal fro                                      |                               |                       | of Disposit<br>on or other | ion (Name                       | of ceme   | etery,                 | July '     | 7 <b>,</b>                 | 20c                    | Location - (                | City or T              | own, State                 |
| imore<br>Pages 1 a<br>nent of H<br>ant: If it  |   | 4 Donation 5  | Other Specify:          |  |                               |                       | emet                       | ery                             |           |                        | 2006       |                            |                        |                             |                        | Maryland                   |
| Baltipernit Departments  | 21. Signature of Furieral Service Licensee 22. Name and Address of Facility |   |                         |  |                               |                       |                            |                                 |           |                        |            |                            |                        |                             |                        |                            |
|  |   | 23a Par / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card   |                         |  |                               |                       |                            |                                 |           |                        |            |                            | Ga1<br>irrest, sh      | ock, or hear                | burg                   | Approximate Interval       |
| Physician<br>/Medical  |   | I uve. List only or   | ne cause on ead         |  |                               |                       |                            |                                 |           |                        |            |                            |                        |                             |                        | Between Onset and<br>Death |
| Examiner   |   | or condition resulting in   |                         | Oue to (or as a                                  |                               | e of):                |                            |                                 |           |                        |            |                            |                        |                             |                        |                            |
| Land P   | Ļ   | Sequentially list condition   |                         | Oue to (or as a                                  | consequence                   | of):                  |                            |                                 |           |                        |            |                            |                        |                             |                        |                            |
|  | nine  | of any, leading to immed<br>cause. Enter Underlying   | g Cause c.              |  |                               |                       | _                          |                                 |           |                        |            |                            |                        |                             |                        |                            |
| executed<br>an and<br>al - transit   | Examiner  | events resulting in death   |                         | Oue to (or as a                                  | consequence                   | e of):                |                            |                                 |           |                        |            |                            |                        |                             |                        |                            |
| - o .º.E   | n/Medical   | UNPENDED  |                         | AMENDED  |                               |                       |                            |                                 |           |                        |            |                            |                        |                             |                        |                            |
| 8760, tificate be ng physici as the buri   | ₩.  | IF FEMALE:<br>23b Was decedent preg   | nant in the             |  | outcome of pr                 | -                     |                            |                                 | 0         | ]e                     |            |                            | 23                     | d Date of c                 |                        | Vasa                       |
| 68<br>certifi  |   | past 12 months?   | indire in the           | 1 Live b   | oirth<br>nant at time of      | all a sea Alla        |                            | al death<br>er <i>(Specif</i> ) | 3         | Ectopic                | pregnano   | су                         |                        | Month                       | Da                     | ay Year                    |
| Box 68 te death cert the attendir  | Physicia  | 1 Yes 2 V No 9  | Unknown                 |  | own                           |                       | - Out                      |                                 | ,,        |                        |            |                            |                        |                             |                        |                            |
| - E 5-5  | by Pr   | Part II. Other significan   | nt conditions           | contributing to                                  | o death but no                | ot resultin           | g in the ur                | nderlying ca                    | ause gi   | ven in Pa              | rt I.      |                            |                        |                             |                        | ne cause of death?         |
| ds, l  | ted   |   |                         |  |                               |                       |                            |                                 |           |                        |            | 24a. Wa                    | as an                  |                             |                        | opsy findings available    |
| COFC<br>law re<br>has be   | Completed   |   |                         |  |                               |                       | -                          |                                 |           |                        |            | per                        | opsy<br>formed?        | de                          | eath?                  | empletion of cause of      |
| Re(<br>The ficate  | Con   |   |                         |  |                               |                       |                            | 200                             | Diago     | of Dooth               | (Check on  | to the same                | s 2                    | No 1                        | ✓ Yes                  | 2 No                       |
| ital<br>ician:<br>certil   | Be  | 25 Was case referred t<br>examiner?   |                         | lospital:  | Inpatient 2                   | ₩ ER/O                | hitnatient                 |                                 |           | Other <sub>4</sub>     |            | Home 5                     | Resid                  | ence 6                      | Other.                 |                            |
| of Vi<br>ing Physi<br>After this<br>uneral dir   | P   | 1 ✓ Yes 2<br>27 Manner of Death   | No                      |  |                               |                       | Time of Ir                 |                                 |           | at Work                |            |                            |                        | jury occurre                | -1-                    |                            |
| Division of Vital Records, pital or Attending Physician: The law require and a fer death erral Director. After this certificate has been signified in by the funeral director, page 2 should b   | ion   | 1 Natural 5   |                         |  | of Injury<br>Day,Year)<br>006 | 212                   | 2 hrs                      |                                 | 1 Y       | es 2 🗸                 | No P       | assenge                    | r auto                 | auto colli                  | sion                   |                            |
| ivisior  I or Attend after death  Director:  | ficat   | 2 Accident 3 Suicide 6  | Investigation Could not | 28e Plan   | e of Injury - A               | t home, f             | arm, stree                 | t, factory, c                   | office bu | ulding, et             | c. 2       |                            |                        | and Number                  | r or Rura              | al Route Number, City      |
| Div<br>ospital or<br>hours aft   | eri   | 4 Homicide  | determined              |  | Interstat                     | e/Expre               | ess                        |                                 |           |                        | I-         | or Town<br>270 @ R         |                        | 5, Frede                    | rick, M                | ld                         |
| Division of Vital Records, P.C To the Hospital or Attending Physician: The law requires that within 24 bours after death completely filled in by the funeral director. Paler this certificate has been signed to completely filled in by the funeral director, page 2 should be deta | Medical Certification:  | 29a Certifier 1 Cer<br>(Check only one) 2 V Med   | tifying Physici         | :On the basis                                    | of examinatio                 | ledge, de<br>n and/or | ath occurr<br>investigati  | ed at the ti                    | me, dat   | te and pla<br>death oc | ace, and d | ue to the ca               | ause(s) a<br>ite and p | nd manner a<br>lace, and du | as starte<br>le to the | d<br>cause(s)              |
| To To COIN   | Med   | 29b. Signature and title  | of certifies            | and manner s                                     | stated                        |                       |                            | 29c.                            | License   | number                 |            |                            | 29d                    | Date signe                  | d (Mont                | th, Day, Year)             |
| 2  |   | Willing   | o Vh                    | e Mr.  | 20                            |                       |                            |                                 | O.C.N     | 1.E.                   |            |                            | Jul                    | y 2, 2006                   | 8                      |                            |
|  |   | 30 Name and address   |                         |  |                               |                       |                            |                                 |           |                        |            |                            |                        |                             |                        |                            |
|  |   | Margarita Kore  |                         | sistant Me                                       |                               |                       |                            |                                 | et, Ba    | altimore               | , MD 2     | 1201                       |                        |                             |                        |                            |
| S<br>Regis   | tate<br>trar  | THE I IS THE THE THE PROPERTY OF THE PROPERTY |                         |  |                               |                       |                            |                                 |           |                        |            |                            |                        |                             |                        |                            |
|  |   |   |                         |  |                               |                       |                            |                                 | _         |                        |            |                            |                        |                             |                        |                            |

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

| Tygrhus Malik Lyle   | 1        | - For State  | /laryland                                    | / Departmen                        |                |   | Mental Hy                     |                        | No. 11-                | 200                           | c -> > > 0 f                       |
|--|----------|--|--|------------------------------------|----------------|---|-------------------------------|------------------------|------------------------|-------------------------------|------------------------------------|
| Physician/   | 1        | tegistrar  1. Decedent's Name (First, Middle,Last)                               |  |                                    |                |   | 2                             | 2. Date of Dea         | Reg. No.<br>ath<br>Day | Year                          | 3. Time of Death                   |
| Medical Examine  |          | Tygrhus Malik  | Lyles  |                                    |                |   |                               | July 5, 20             | 006                    |                               | 1840 hrs                           |
|  |          | 4a Facility Name (if not institution, give stree<br>Fort Washington Medical Cent |  |                                    | - 1            | . City, Town, or Lo<br>Fort Washing     |                               |                        |                        | County of Death               |                                    |
| Funeral  | 1        | 5. Social Security Number 6. Sex   | 7 Ag   | e (In yrs last birthda             | ay)            | If Under 1 Year                         | If Under 24Hrs.               | 8. Date of B           |                        | D/YYYY) 9. Birt               | hplace (State or                   |
| Director   | 1        | 578-98-7910 1xM  | 2_F  | 29                                 | Yrs.           | Months Days                             | Hours Min.                    | Apri                   | 1 20                   | Foreig                        | Wash.,DC                           |
|  |          | Usual Residence of Decedent  10a. State 10b. County                              |  | 10c. City, Town or I               |                |   |                               |                        |                        |                               | 10d. Inside City Limits            |
| d<br>Fe.   | 1        |  |  |                                    |                |   |                               |                        |                        |                               | 1 X Yes 2 No                       |
| the Maryland<br>a or 28a-f sh<br>tifted at once  | 3        | MD . PG  10e. Street and Number  |  | Oxon                               |                | 10f. Zip Code                           |                               |                        | 10g. Citize            | en of What Cour               | ntry?                              |
| with the Maryland<br>s 23a or 28a-f show a<br>enotified at once,<br>ral Director   |          | 7907 Indian Head   | Highw  | vay #101                           |                | 20745                                   | 5                             |                        | Unit                   | ted Sta                       | ates                               |
| r death with<br>or items 23<br>must be no  | <u> </u> |  | Nas Decedent<br>Armed Forces?                |                                    |                | Decedent of Hispa<br>, specify Cuban, I |                               |                        | 0- 1                   | 14 Race - Ameri<br>White, etc | can Indian, Black,                 |
| r nus  | -        | 3 Widowed 4 Divorced If Yes  |  | X No                               | 1 N            | es 2 X No                               | specify:                      |                        | .5                     | Specify Rla                   | -1-                                |
| ours aft<br>autural"<br>amine  |          | 15. Decedent's Education (Specify only hig                                       | tes:   |                                    | cedent's       | Usual Occupation                        | n (Give kind of wo            |                        |                        | nd of Business/               |                                    |
| 6<br>n 72 ho<br>an "na<br>ical Es  |          | Elementary/Secondary (0-12)  | ollege (1-4 or                               | 5+) dur                            | _              | t of working life.                      |                               | a)                     |                        |                               |                                    |
| 5-0036 lited within 72 hour Hygiene I other than "natt the Medical Exa   | <u> </u> | 17. Father's Name (First, Middle, Last)  | 2  | i                                  |                | Manager<br>118                          | Mother's Name (               | First, Middle,         |                        | Surname)                      |                                    |
| 215<br>be filed<br>mtal Hy<br>rrked of<br>ent, th  |          | Ronald Lyles   |  |                                    |                |   | Delores                       |                        | lton                   | ,                             |                                    |
| Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Department (Filem 27 is unarked other than "natural", or items 23a or 28a-f she important: If item 27 is unarked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director | 2 [      | 19a Informant's Name/Relationship (Type, F<br>Delores Lyles/mot                  | ,  | 79                                 | 907            | ddress (Street a                        | Head I                        | ral Route Nu<br>Jighwa | mber, City             | y or Town, State<br>101       | Zip Code)                          |
| e, M<br>L and 2<br>Health<br>item 2  | t        | 20a Method of Disposition  |  | 20b. Place of D                    |                | on (Name of ceme                        |                               | Date                   |                        | ocation - City or             | Town, State                        |
| mor<br>Pages<br>ent of<br>nt: If   |          | 1 X Burial 2 Cremation 3 Red 4 Donation 5 Other Specify:                         | emoval from St                               |                                    |                | iem. Pai                                | ck 7/1                        | 1/06                   | La                     | andovei                       | Md.                                |
| Baltimore, permit. Pages I an Ocpartment of Hee Important: If ite Important: If ite Injury or other ir   | ľ        | 21. Signature of Funeral Service Licensee  | А  |                                    | 22. <b>N</b> a | me and Address o                        | f Facility HO                 |                        | & Ec                   | dwards                        | F.H.                               |
|  | 4        | 232 Part I. Enter the disease, or complication                                   | MOL 2  |                                    |                |   |                               |                        |                        |                               | MD . 20746 Approximate Interval    |
| Physician<br>/Medical  |          | failure. List only one cause on each lin   | ∍.   | onoxide into                       |                |   | 20.1 40 04.4.40               | 00p.12(01) GI          | 1001, 01100            | N, or riodit                  | Between Onset and<br>Death         |
| Examiner   |          | miniodidio Cadoo (i mai dioseco  | o (or as a cons                              |                                    |                |   |                               |                        |                        |                               |                                    |
| 1  |          | Sequentially list conditions, if any, leading to immediate Due to                | o (or as a cons                              | equence of)                        |                |   |                               |                        |                        |                               |                                    |
| red Insit  |          | cause. Enter Underlying Cause  |  |                                    |                |   |                               |                        |                        |                               |                                    |
|  |          | evente resulting in death) Last  | o (or as a cons                              |                                    |                |   |                               |                        |                        |                               |                                    |
| 60, Le be executed ysician and burial - transit  | 2        | X UNPENDED AM  | ENDED ITE                                    | <del>n#23a,PII,2</del> 7           | 7,28a          | -f,perME,g                              | 85/ <b>,</b> //28/C           | <del>l) 11</del>       | -                      |                               |                                    |
| 760, Icate be physici the buri   | ME       | IF FEMALE: 23 3b Was decedent pregnant in the                                    |  | me of pregnancy                    |                |   | le                            |                        |                        | Date of delivery              |                                    |
| Ox 6876 sath certificate attending phy or use as the l   | 2        | past 12 months?  | Live birth Pregnant at                       | time of death 5                    | _              | death 3                                 | Ectopic pregnant              | СУ                     | '                      | Month D                       | ay Year                            |
| D. Box the death of the attent by the attent sched for us  |          | 1 Yes 2 No 9 Unknown 9   | Unknown                                      |                                    |                |   |                               | 1                      |                        |                               |                                    |
| n of Vital Records, P.O. Box 6876 ing Physician: The law requires that the death certificat After this certificate has been signed by the attending phythmeral director, page 2 should be detached for use as the bin: To Re Completed by Physician/M  | ል        | Part II. Other significant conditions cont<br>Multiple sclerosis                 | ibuting to deat                              | h but not resulting in             | n the un       | derlying cause giv                      | en in Part I                  |                        |                        |                               | the cause of death? ably 4 Unknown |
| Records,  The law require: ficate has been sig. page 2 should be   | erec     | - Taranja octavono   |  |                                    |                |   | _                             | 24a Was                |                        | 24b Were au                   | opsy findings available            |
| e law i  |          |  |  |                                    |                |   |                               |                        | ormed?                 | death?                        | ompletion of cause of              |
| un: The  |          | 25. Was case referred to medical   |  |                                    |                |   | f Death (Check or             | 1 Yes                  | 2 No                   | 1 ✔ Ye                        | s 2 No                             |
| of Vital Records,  g Physician: The law requir ther this certificate has been s neral director, page 2 should 1  | ۱۰       | examiner?  1 ✓ Yes 2 No  | 1 Inpatte                                    | ent 2 🗸 ER/Outp                    |                |   |                               | Home 5                 | Residen                | ce 6 Other                    |                                    |
| in of Ning Ph.   |          | 27. Manner of Death  1 Natural 5 Pending   | 8a. Date of Inju<br>(Month, Day.)<br>Fnd 7/5 | (ear)                              |                |   | at Work? 2<br>s 2 <b>y</b> No | 8d Describe            | how injur              | y occurred                    |                                    |
| Division rate of an artification   | Eal      | 2 Accident Investigation   |  | njury - At home, farm              |                | <u>r</u>                                |                               | unk<br>8f Location (   | Street an              | d Number or Rui               | al Route Number City               |
| Division o<br>spital or Attending<br>hours after death<br>nneral Director: Aft<br>v filled in by the fune<br>Centification:  |          |  | (Specify)                                    | found at                           | t hor          | e                                       |                               | Bryans .               | Road,                  | MG Gerra                      | al Route Number City<br>and Court  |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death in 17 on the funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the benchical Certification: To Re Commisted by Physician/Me                                    | - 1      | 29a Certifier 1 Certifying Physician: T one) 2 Medical Examiner: On the and      |  |                                    |                |   |                               |                        |                        |                               |                                    |
| E S I S  | <b>₹</b> | 29b Signature and title of certifier   | Λ Λ  | 1                                  |                | 29c. License                            |                               |                        | 1                      | ate signed (Mor               | th. Day, Year)                     |
|  |          | Tata Grania  | -15ll  | dus                                |                | O.C.M                                   | .E.                           |                        | July                   | 7, 2006                       |                                    |
|  |          | 30 Name and address of person who complete Patricia Aronica-Pollak MD.           |  | death (Item 23a)<br>Medical Examin | er '           | I11 Penn Stre                           | et, Baltimore                 | MD 2120                | )1                     |                               |                                    |
| Stat<br>Registra   | _        | 31. Date filed (Month, Day, Year) JUL 2 0 2006                                   | 32 Registra                                  | ar's Signature                     | cook           | P.A                                     |                               |                        | ·                      |                               |                                    |
|  |          |  | AT   |                                    |                |   |                               |                        |                        |                               |                                    |

State of Maryland / Department of Health and Mental Hygiene) 22802 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day Year Month **Physician** 11:42 PM JULY 02 AMY LOUISE MILTON 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL MONTGOMERY OLNEY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖾 F Yrs. 220-19-6220 Director 68 MARCH 23, 1938 JAMAICA. W.I. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner court be notified at 1 ☐ Yes 2 🖾 No MARYLAND MONTGOMERY SILVER SPRING Director 10e Street and Number 10f Zin Code 10g. Citizen of What Country? s filed within 72 hours after death with I Hygiene.
other then "naturel", or Iteme 23a or 3728 CAPULET TERRACE 20906 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ BLACK. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 NURSE HEALTHCARE SERVICES permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe eny injury or other traumatic assets 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be AUGUSTUS GRANT ELLA CHEVANNAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANKLIN T. MILTON - SPOUSE 3728 CAPULET TERRACE, SILVER SPRING, MARYLAND 20906 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GATE OF HEAVEN CEMETERY JULY 10, 2006 SILVER SPRING, MARYLAND 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Pure to (or as a consequence of): Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of) **Examiner** CARDIOMEGALY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit HYPERTENSION Due to (or as a consequence of). Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☒ No Records, P.O. 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ OBESITY 1 Yes 2 No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 A No 2□ No 1 Yes Division of Vital il or Attending Physician: after death. Director: After this entifice Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 X ER/Outpatient 3 □ DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28c. Injury at Work? 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Tyes 2 No М 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2006 03 MD14686 O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

0 6 2006

ORIGINAL

WINSTON R. FREDERICK, M.D., 1160 VARNUM STREET, NE, SUITE 016, WASHINGTON, D.C. 20017

32 Registrar's Signature

|            |   |                  | For<br>Stata<br>Registrar   | State of Ma  | aryland / Depa                             | artment of H                               |                          |                                      | ene 006                        | 22803  |
|------------|---|------------------|---|--|--|--|--------------------------|--------------------------------------|--------------------------------|--|
|            |   |                  | 1. Decedent's Name (First, Middle,  | Last)  | -  |  |                          | 2. Date of Death                     |                                | 3. Time of Death                                   |
| ш          | Physici   |                  | EVA +   | IELEN  | MARUSAK                                    |  |                          | July                                 | 7. 2006                        | 12:25 P <sup>M</sup>                               |
|            | /Medic<br>Examin  |                  | 4a. Facility Name (If not institution,  |  | HAHOSAK                                    | 4b. City, Town, or                         | Location of Deat         |                                      | 4c. County of Deat             |  |
| 1          | LAdimii   | CI               | C J's Assiste   |  |  | Hager                                      | stown                    |                                      | Washi                          | ngton  |
| -          | Euparal   |                  |   |  | e (In yrs. last birthday)                  | If Under 1 Year                            | If Under 24 Hrs.         | 8. Date of Birth                     | 9. Birt                        | holace (State or Foreign                           |
|            | Funeral<br>Director   |                  | 553-54-3453   | 1 □ M 2 🗙 F  | 92 Yrs.                                    | Months Days                                | Hours Min.               | December                             | 24,1913 C                      | New Jersey   |
|            |   |                  | Usual Residence of Decedent   |  |  |  | 1,1                      |                                      |                                |  |
|            | yland   |                  | 10a. State 10b. County  |  | 10c. City, Town or Lo                      |  |                          |                                      |                                | 10d. Inside City Limits                            |
|            | Mar   | to               | Maryland Wash   | ington   | Hage:                                      | rstown                                     |                          |                                      |                                | 1 ☐XYes 2 ☐ No                                     |
|            | r 288   | rec              | 10e. Street and Number  |  |  | 10f. Zip Code                              |                          | 10                                   | g. Citizen of What Co          | untry?   |
|            | filed within 72 hours after death with the Maryland<br>Hygione.<br>ther than "natural", or Itams 23a or 28a-f ahow<br>ant, the Medical Examinar must be notified at | Funeral Director | 145 King Str  | eet  |  | 21740                                      | )                        |                                      | U.S.A.                         |  |
|            | ms 2  | era              | 11. Marital Status  |  | Ever in U.S. 13.                           | Was Decedent of H                          | ispanic Origin? (S       | pecify Yes or No-                    | 14. Race - Ame                 |  |
| (0         | or Ita  | Ē                | 1 ☐ Never Married 2 ☐ Marrie  | 12. Was Decedent Armed Forces?                       | No   |  |                          | o Rican, etc.)                       | Black, White                   | e, etc.  |
| 93         | urs a   | þ                | 3X Widowed 4 ☐ Divorced   | If Yes, Give<br>Year or Dates:                       |  | 1 ☐ Yes 2 💢 No                             | Specify:                 |                                      | Specify: W                     | hite   |
| 21215-0036 | 2 ho  | Completed        | 15. Decedent's  | Education  | 16a. Dece                                  | dent's Usual Occup                         | ation                    | 1                                    | 6b. Kind of Business/          | Industry   |
| 75         | nin 7   | ple              | (Specify onfy highest<br>Elementary/Secondary (0-12)  | Grade completed)  College (1-4or 5                   | (Give                                      | kind of work done of<br>DO NOT use retired | during most or wor<br>f) | rking                                |                                |  |
| 212        | f with  | Eo               | Elementary/Secondary (0-12)   | 4  | Scl  | nool Tea                                   | cher                     |                                      | Public                         | Schools  |
| ਰੂ         | Hyg<br>othe   | Be C             | 17. Father's Name (First, Middle, La  | ist)   |  |  | 18. Mother's Nar         | ne (First, Middle, M                 |                                |  |
| an         | ental<br>kad<br>kad   | To B             | Jacob   | St   | ankiewic                                   | z  | Hele                     | ena                                  | Wal                            | ewska  |
| Maryland   | 2 should be filed v<br>n and Mental Hygie<br>Is markad other t<br>raumatic evant, III   | -                | 19a. Informant's Name/Relationshi   | р (Турө, Print)                                      | 19b. Maili                                 | ng Address (Street                         | and Number or Ru         | ıral Route Number,                   | City or Town, State, 2         |  |
| Z          | and 2<br>salth a<br>n 27 is   |                  | Eve J. Mc Gr  | ory  | 1271                                       | 7 Lindea                                   | / Lane                   | danerstow                            | n, Marylan                     | d 21742  |
| ō,         |   | 1 8              | 20a. Method of Disposition  | ,  | 20b. Place of Dispo                        | sition (Name of                            |                          |                                      | Oc. Location - City or         |  |
| و          | 0 0   |                  | 1 ☐ Burial 2 🗡 Cremation 3  |  |  | natory or other plac                       | - 1                      | 20.00                                | 22                             | M (0.00  |
| Baltimore, |   |                  | * 4 □ Donation 5 □ Other (Special Service Li  |  | Hagerstow                                  |  |                          |                                      | agerstown,                     |  |
| Ba         | permit. Departr Importa any inju  |                  | R. hast   |  | Ąr   | drew K.                                    | Coffman_I                | -<br>Uneral H                        | ome, Inc.<br>gerstown,         |  |
|            | 40240   |                  | 7-11-0-0-0  |  | 40   | ) East An                                  | tietam Si                | treet, Ha                            | gerstown,                      | Md. 21740  |
|            |   |                  | 23a. Part1. Enter the disease, or c<br>shock, or heart failure. List or   | omplications that caused<br>by one cause on each li- | ne.  | er the mode of dyin                        | g, such as cardiad       | or respiratory arre                  | st,                            | Approximate<br>Interval Between<br>Onset and Death |
|            | Pnysician   | 3 1              | Immediate Cause (Final disease or condition   | 2  | COLITI                                     | C  |                          |                                      |                                | Onset and Death                                    |
|            | /Medical  |                  | resulting in death)   |  | a consequence of):                         | 7  |                          |                                      |                                |  |
|            | Examiner  |                  | Conventially list conditions  | b  | C. DIFFI                                   | cle.                                       |                          |                                      |                                |  |
|            |   | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of Injury that is listed events.) | Due to (or as  | a consequence of):                         |  |                          |                                      |                                |  |
|            | be executed<br>sician and<br>burial-transit   | Examiner         | Cause (Disease or injury that initiated events  | G  |  |  |                          |                                      |                                |  |
| Ć          | execting and and ital-tr  | Exa              | resulting in death) Last  | Due to (or as  | a consequence of):                         |  |                          |                                      |                                |  |
| 8760,      | iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit                | dicai            |   | d  |  |  |                          |                                      |                                |  |
| 68         | ificate<br>g phys   | 0                |   |  |  |  |                          |                                      |                                |  |
| ŏ          | death certifica<br>attending ph<br>I for use as th  | M                | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome                                 |  |  |                          |                                      | 23d. Date of deli              | very   |
| m          | atte<br>atte  | Cia              | in the past 12 months?  | 1 Live birth<br>4 Pregnant at                        |  | Ectopic pregnancy Other (specify)          | '<br>                    |                                      | Month                          | Day Year   |
| 0          | that the di<br>ed by the<br>detached  | Physician/M      | 9 Unknown   | 9□ Unknown   |  |  |                          |                                      |                                |  |
| ۵.         | res that the signed by be detact  |                  | Part II. Other significant condition  | s contributing to death b                            | out not resulting in the u                 | nderlying cause giv                        | en in Part I.            | 23e. Did tob                         | acco use contribute to         | the cause of death?                                |
| Records,   | sign<br>d be  | d b              | CKD CHP   | HENES  | CTENPIO.                                   | <i>√</i> .                                 |                          | 1 □ Ye:                              | s 2 <b>⊠</b> No 3⊟Pr           | obably 4 Unknown                                   |
| Ö          | w requir<br>been si<br>should   | ete              | 1   | )  | J  |  |                          |                                      | 1.00                           |  |
| ec         | has l   | ldu              |   |  |  |  |                          | 24a. Was an<br>autopsy<br>perform    | orior to o                     | topsy findings available<br>completion of cause of |
|            | The i   | Completed by     |   |  |  |  |                          | 1 ☐ Yes 2                            | ed? death?<br>■ No 1 □ Yes     | 2 🗆 No   |
| of Vital   | ding Physician: The law<br>n.<br>After this certificate has b<br>funeral director, page 2 s   | Be               | 25. Was case referred to medical examiner?  | 111 - 21   |  |  |                          | ath (Check only one                  | )                              | Assisted   |
| =          | Shysi<br>this c   | 2                | 1 ☐ Yes 2 💢 No  | Hospital: 1 ☐ Inpatie                                |  |  | 4   Nursing F            | lome 5 🗆 Resider                     | nce 6 X Other (Spec            | ity)Living   |
| _          |   | :uc              | 27. Manner of Death  1   ✓ Natural 5   ☐ Pending  | 28a. Date of Inju<br>(Month, Da                      | ury 28b. Time o<br>ly Year) Injury         | f 28c. Injun<br>Wor                        | y at<br>k?               | 28d. Describe how                    | w injury occurred              |  |
| .0         | Attending r death. actor: After by the fune   | ath              | 2 Accident investiga  | ition  |  | M 1  | Yes 2 ☐ No               |                                      |                                |  |
| Division   | er de<br>racte  | tific            | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determin   | 289. Place of Inj                                    | jury - At home, farm, str<br>tc. (Specify) | eet, factory, office                       |                          | 28f. Location (Str.<br>City or Town, | eet and Number or Ru<br>State) | ral Route Number,                                  |
|            | ospital or A<br>hours after<br>unaral Dira<br>ly filled in by   | Certification:   |   | W.   |  |  |                          |                                      |                                |  |
|            | To tha Hospital or Attenswithin 24 hours after deatl To tha Funaral Diractor:   |                  | 29a. Certifier 1 Certifying (Check only 2 Medical E   | Physician: To the best<br>xaminer: On the basis o    | of my knowledge, deat                      | h occurred at the tin                      | ne, date and place       | , and due to the car                 | use(s) and manner as           | stated.  |
|            | within 24 To the Fi   | edical           | one)  | and manner st  | ated.                                      | vostigation, in my o                       | pilloli, deali occi      | ared at the time, da                 | te and place, and due          | to the cause(s)                                    |
|            | To t<br>To t  | Σ                | 29b. Signature and title of certifier   |  |  | 29c. Licens                                | e number                 | 29                                   | d. Date signed (Month          | n, Day, Year)                                      |
|            |   |                  | 1 le 162  | y mg   |  | D-2  | 2313                     |                                      | July 7                         | , 2006   |
|            |   |                  | 30. Name and address of person w  | no completed cause of (                              | death (Item 23a) (Type,                    | Print)                                     |                          |                                      | -                              |  |
| 34         | 1-6   |                  | Eli Roza M  |  | Oak Hill                                   |  | Hagers                   | town, M                              | aryland :                      | 21742  |
|            | Sta   | ate              | 31. Date filed (Month, Day, Year)   |  | rar's Signature                            |  | <u>_</u>                 |                                      |                                |  |
|            | Regist  |                  | JUL 1 (   | 2006   | mar A. D                                   | artes                                      |                          |                                      |                                |  |

|                |  |               | - State<br>Registrar  | State of Ma  |                           |  | of Health and of Death                              | F                                     | Reg. No.                   | 6 22801                         |
|----------------|--|---------------|---|--|---------------------------|--|---|---------------------------------------|----------------------------|---------------------------------|
|                | Dhualat  |               | Decedent's Name (First, Middle, Last)   |  |                           |  |   | 2. Date of Dea                        | ith<br>Day Yea             | 3. Time of Death                |
|                | Physicia<br>/Medic   |               | Dorothy E.  | McKay  |                           |  |   | July 3,                               |                            | 12:15 P M                       |
|                | Examin   |               | 4a. Facility Name (If not institution, give s   | treet and number)  |                           | 4b. City, T                                | own, or Location of Dea                             | th                                    | 4c. County of De           |                                 |
|                |  |               | 3701 Internation  | al Drive,  | #416                      | Silve                                      | er Spring   |                                       | Mon                        | tgomery                         |
|                | Funeral  |               | 5. Social Security Number 6. Sex  |  | (In yrs. last birthday,   |  | Year If Under 24 Hrs                                |                                       | n 9. B                     | irthplace (State or Foreign     |
|                | Director   |               | 579-26-7100   | M 25kF   | 82 Yrs.                   | MOITING                                    | Days Hours Will                                     |                                       | 0. 1924 Vi                 | **                              |
| П              | p .  |               | Usual Residence of Decedent  10a, State 10b, County                                   |  | 10-01-7                   |  |   |                                       |                            | <del></del>                     |
|                | aryla<br>Bhov  |               | 28 - 287  |  | 10c. City, Town or L      |  |   |                                       |                            | 10d. Inside City Limits         |
|                | Ba-f   | cto           | Maryland Montgome   | ry   | Silver                    |  |   |                                       |                            | 1 ☐ Yes 2 ☐ No                  |
|                | ith th   | Director      | 10e. Street and Number  |  |                           | 10f. Zip 0                                 | Code  |                                       | 10g. Citizen of What (     | Country?                        |
|                | 23a  | ia            | 3701 Internationa   |  |                           | 2090                                       | 6   |                                       | USA                        |                                 |
|                | ar de  | Funerai       |   | <ol><li>Was Decedent Endemoder</li><li>Armed Forces?</li></ol> |                           | Was Decede<br>If Yes, specif               | ent of Hispanic Origin? (<br>fy Cuban, Mexican, Pue | Specify Yes or No-<br>no Rican, etc.) | 14. Race - An<br>Black, Wh | nerican Indian,<br>nite, etc.   |
| 9              | 72 hours after death with the Maryland<br>natural; or iteme 23a or 28a-f show<br>disal Examinar must be notified at  | by F          | 1 Never Married 2 Married   | 1 ☐ Yes 2 ☐ No<br>If Yes, Give                                 |                           | 1 Tes 2                                    | ☐ No Specify:                                       |                                       | Specify: W                 | hite                            |
| Š              | urai'  | D<br>D        | 3 ☑ Widowed 4 ☐ Divorced  | Year or Dates:   |                           |  |   |                                       |                            |                                 |
| 21215-0036     | nat<br>nat   | Completed     | 15. Decedent's Educ<br>(Specify only highest grade                                    | completed)   | (Give                     | dent's Usual<br>kind of work<br>DO NOT use | c done during most of wo                            | orking                                | 16b. Kind of Busines       | s/Industry                      |
| 2              | withir<br>then<br>then   | ם             | Elementary/Secondary (0-12)   | College (1-4or 5+  | ) ""e.                    |  |   |                                       |                            |                                 |
| N              | lied<br>lygie<br>ther<br>nt.   |               | 17. Father's Name (First, Middle, Last)   |  |                           | Homem                                      |   | me /First Middle                      | Own F<br>Maiden Sumame)    | ome                             |
| Maryland       | d old  | Be            | V 1000  |  |                           |  |   |                                       | ,                          |                                 |
| Ž              | 1 Me<br>nark<br>natio  | 2             | John Mothershead  19a. Informant's Name/Relationship (Type                            | D  | 405 44-17                 |  |   | erta Bal                              |                            |                                 |
| Z<br>Z         | 12 st<br>h an<br>7 is r<br>traur   |               | Joan R. Bartlett/N  | •  |                           |  | (Street and Number or R                             |                                       |                            |                                 |
| о<br>О         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merial Hygiene. Important: if item 27 is marked alther than "natural; or items 23a or 28a-f show army loury or other traumatic event, the Maritral Examinar must be notified at 20.00. |               | 20a. Method of Disposition  | Tece   | 20b. Place of Disp        |  | ornsville R   | Date Cul                              | 20c. Location - City of    |                                 |
| Baltimore,     | 90 = 0 B   |               | 13€ Burial 2 ☐ Cremation 3 ☐ R  | emoval from State  | cemetery, cre             | matory or oth                              | her place) July                                     |                                       | 20c. Location - City (     | or rown, State                  |
|                | tant<br>iury   |               | 4 □ Donation 5 □ Other (Specify)  |  | Parklawn M                |  | 200   |                                       | ockville,                  | Maryland                        |
| ā              | permit.<br>Departm<br>Importa<br>any inju  |               | 21. Signatur o Funeral Service License  | ° ( 0.   | F <sup>2</sup>            | 2 Name and<br>Cancis                       | Address of Facility ns                              | Funeral                               | Home Inc.                  |                                 |
| _              | Ø 0 ≥ € Ø  |               | mohen   | Love   |                           |  | versity Blv   |                                       |                            | g, MD 20901                     |
|                |  |               | 23a. Part1. Enter the disease, or complications shock, or heart failure. List only of | cations that caused t<br>e cause on each line                  | he death. Do not en<br>e. | ter the mode                               | of dying, such as cardia                            | ic or respiratory ar                  | rest,                      | Approximate<br>Interval Between |
| V              | Physician  |               | Immediate Cause (Final disease or condition   | Coronary   | Artery D                  | isease                                     |   |                                       |                            | Onset and Death 35 Years        |
| 4              | /Medical   |               | resulting in death)   |  | consequence of):          |  |   |                                       |                            | Jo rears                        |
|                | Examiner   |               | Sequentially list conditions, b   | Hypercho   | lesterole                 | mia  |   |                                       |                            | 35 Years                        |
|                | D =  | ner           | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury         | Due to (or as a  | consequence or):          |  |   |                                       |                            |                                 |
|                | cute<br>nd<br>rans   | Examiner      | that initiated events C   | Hyperten   |                           |  |   |                                       |                            | 20 Years                        |
| Ö              | e exe  | Ĕ             | resulting in death) Last  | Due to (or as a  | consequence of):          |  |   |                                       |                            |                                 |
| 68760,         | ificate be executed<br>g physicien and<br>as the burial-transit  | edical        |   |  |                           |  |   |                                       |                            |                                 |
| _              | ng pt  |               | IF FEMALE:  |  |                           |  |   |                                       |                            | 1                               |
| Вох            | death cert<br>e attending<br>id for use a  | an/           | 23b. Was decedent pregnant  | 3c. If yes, outcome o  |                           | ⊒Ectopic pre                               | onancy  |                                       | 23d. Date of d             |                                 |
|                | dea<br>se att  | stcia         | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4☐Pregnant at to<br>9☐Unknown                                  |                           | Other (spe-                                |   |                                       | Month                      | Day Year                        |
| 0              | thet the death certificed by the attending I detached for use as   | Physician/M   | 9 Unknown   | 3LI OTIKITOWIT   |                           |  |   |                                       |                            |                                 |
|                | 5 6 5  | by            | Part II. Other significant conditions con   | tributing to death but   | not resulting in the u    | underlying car                             | use given in Part I.                                | 23e. Did to                           | bacco use contribute       | to the cause of death?          |
| Vital Records, | w requires<br>been sign<br>should be   |               | End-Stage Chronic   | Obstructi  | ve Pulmona                | ary Di                                     | sease   | 1 <del>/</del> /                      | 'es 2 □ No 3 □ l           | Probably 4 Unknown              |
| ပ္က            | > 11 0   | Completed     |   |  |                           |  |   | 24a Was                               |                            | autopsy findings available      |
| ř              | 0 5 0  | E             |   |  |                           |  |   | autop                                 | med?   death?              |                                 |
| ā              | ician: Th<br>certificete<br>ector, pag   | 0             | 25. Was case referred to medical  |  |                           | <del></del>                                | 26 Place of De                                      | 1 ☐ Yes<br>eath (Check only o         |                            | es 2 No                         |
|                | Physician:<br>this certific<br>ral director,   | ToB           | examiner?<br>1 ☐ Yes 2 ☒ No   | ospital:   | t 2 ER/Outpatie           | nt 3 DOA                                   | Othor   |                                       | lence 6 □Other (Sp         | necifu)                         |
| ō              |  |               | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day                             |                           |  | lc. Injury at<br>Work?                              |                                       | ow injury occurred         | ocny)                           |
| <u></u>        | nding I<br>uth.<br>r: After<br>e funer   | at io         | 1 Natural 5 Pending 2 Accident investigation  | (Month, Day  | Year) Injury              | м  | Work?<br>1 ☐ Yes 2 ☐ No                             |                                       |                            |                                 |
| Division       | Attending<br>ir death.<br>ector: After<br>by the fune  | ertification: | 3 ☐ Suicide 6 ☐ Could not be  | 28e. Place of Injur  | ry - At home, farm, st    | reet, factory,                             | office  | 28f. Location (S                      | treet and Number or        | Rural Route Number,             |
| ā              | o effe   | ert           | 4  Homicide   | building, etc.   | (эрөсіту)                 |  |   | City or Tow                           | m, State)                  |                                 |
|                | To the Hospital or Attend within 24 hours effer death To the Funeral Director: , completely filled in by the f   | alC           | 29a Certifier 12 Certifying Phys  | ician: To the best of  | my knowledge, dos         | th Sonumad a                               | it the time, date and place                         | ie and due to the o                   | ausa(s) and manner         | is stated.                      |
|                | the Ho<br>Jin 24 h<br>the Fu   | edic          | (Check only 2 Medical Examinations)   | ner: On the basis of and manner stat                           | exagnination and/or in    | rvestigation, i                            | in my opinion, death occ                            | curred at the time, o                 | date and place, and d      | ue to the cause(s)              |
|                | To the within To the comple  | Me            | 29b. Signature and title of certifier   | 1//  | 0                         | 29c.                                       | License number                                      |                                       | 29d. Date signed (Mo       | nth, Day, Year)                 |
|                | _  |               | New A   | Meta   | , and                     |  | D41460  |                                       | Jul                        | y 5, 2006                       |
| •              | 5  |               | 30. Name and address of person who co   | mpleted cause of de  | ath (Item 23a) (Type      |  |   |                                       |                            |                                 |
|                |  |               | Francisco Matheus   |  |                           |  | nue, Wheato   | on, MD 20                             | 902                        |                                 |
|                | Sta  | ate           | 31. Date filed (Month, Day, Year)   | 32. Registra   | r's Signature             | booth                                      |   |                                       |                            |                                 |
|                | Registr  | 101           | HH 0.6.21   | 306 4  | 16 6                      | THE PERMIT                                 |   |                                       |                            |                                 |

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician**  $J_{u}^{\text{MODIO}} 5$ 2006 12:50 AM NATHANSON Simona /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Valley Nursing & Wellness Ctr. Rockville Montgomery 7. Age (In yrs. last birthday)

Months Days Hours Min.

Worth Day, Year 909 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ F Pennsylvania 577-50-8161 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ehow other then "naturel", or items 23a or 28a-f ehovent, the Medical Examiner must be notified at 1 Yes 2 No Directo Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 United States 1235 Potomac Valley Road or items 23a Completed by Funeral filad within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 Ho Specify: Baltimore, Maryland 21215-0036 3 X Widowed 4 ☐ Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hotel Office Manager parmit. Pages 1 and 2 should be filed w
Dapartmant of Haalth and Mantal Hygia
Importeer: If Item 27 is marked other 1
any injury or other treumatic event, in
one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Brown Ida Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ina Goldstein, Daughter 14801 Cobblestone Drive, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 07/09706 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Falls Church, VA King David Memorial Garden 21. Signature of Funeral Service License 22. Name and Address of Facility Torchinsky Hebrew Funeral Home St. cardiac of Washington, DC Carroll Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner 1 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of) Examiner ed by the attending physician and datachad for use as the burial-transit or Attending Physicien: The law requiras that the death cartificate be exacuted Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 □ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tor: Aftar this cartificata has baan signitha funaral diractor, paga 2 should ba 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending daath. 1 Tes 2 No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillad in by 4 - Homicide within 24 hours after To the Funeral Dire Hospital Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Menth, Day, Year) 0062435 90 of death (Item 23a) (Type, Print) Machta late De 31. Date filed (Month Day, Year) State 06 2006

Registrar

|              |  | 1              | For<br>State<br>Registrar   | :                       | State                     | of Mai                 | ryland           | l / Depa          | artmei<br><i>tifica</i> | nt of H<br>te of I       | ealth a<br>D <i>eath</i>   | and M                    | ental I                                 | Hygie<br>Reg  |                    | 06                      | 228                              | 305           |
|--------------|--|----------------|---|-------------------------|---------------------------|------------------------|------------------|-------------------|-------------------------|--------------------------|----------------------------|--------------------------|---|---------------|--------------------|-------------------------|----------------------------------|---------------|
| -            | 0 8  |                | Decedent's Name (First, Middle  | e. Last)                |                           |                        |                  |                   |                         |                          |                            |                          | 2. Date of                              |               | 140.               |                         | 3. Time o                        | f Death       |
|              | Physicia   | ın             | Lewis   | J, 2001)                |                           | Do                     | truc             | celli             |                         |                          |                            |                          | Month                                   | 20            | Day                | Year                    |                                  | рм            |
|              | /Medic   |                | 4a. Facility Name (If not institution   | n circo et              | root and n                |                        | cruc             | celli             | 4b Cib                  | Town or                  | Location of                | of Death                 | June                                    | 30            | , 200<br>4c. Count |                         | 9:30                             | -             |
|              | Examin   | er             | 4a. Facility Name (II not institution   | i, give sti             | reet and ni               | umber)                 |                  |                   |                         |                          |                            | Death                    |   |               |                    | •                       |                                  |               |
|              |  |                | 5225 Pooks Hi 5. Social Security Number   | 11 R                    | oad,                      |                        |                  | N<br>st birthday) |                         | ethes<br>er 1 Year       |                            | 24 Hrs.                  | 8. Date of                              | Righ          | Mont               | -                       | ry<br>hplace (State              | or Foreign    |
|              | Funeral  |                |   |                         | M 2□F                     | /. Age                 |                  | Yrs.              | Months                  |                          | Hours                      | Min.                     | (Month                                  | Day, Y        |                    | Co                      | nuntry)                          | or roreign    |
| W.           | Director   | -              | 213-56-9736 Usual Residence of Decedent   |                         |                           |                        | 54               |                   |                         | 1                        |                            |                          | sept.                                   | 26            | , 195              | 1 1                     | taly                             |               |
|              | Due ≱  | -              | 10a. State 10b. County  | ,                       |                           |                        | 10c. City,       | Town or Lo        | cation                  |                          |                            |                          |   |               |                    |                         | 10d. Inside C                    | ity Limits    |
|              | aho<br>aho   | 5              |   |                         |                           |                        |                  | _                 |                         | _                        |                            |                          |   |               |                    |                         | 1 🗌 Yes                          | 2 <b>X</b> No |
|              | 7 94 1-188 1 | Director       | Maryland Montg  | omer                    | У                         |                        |                  |                   | Beth                    | esda_<br>ip Code         |                            |                          |   | 100           | . Citizen of       | Mhat Ca                 |                                  |               |
|              | To a   | 급              | 10e. Street and Number  |                         | _                         |                        | -10              |                   | 101. 2                  |                          | 07.4                       |                          |   | 109           |                    |                         | ountry:                          |               |
|              | be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural", or items 23a or 28a-1 ahow event, the Medical Examinar most be notified at  | Funeral        | 5225 Pooks Hi   |                         |                           |                        |                  |                   |                         |                          | 814                        | -:-0.10-                 | 7. 14                                   | N             |                    | SA                      | dana tanting                     |               |
|              | ar de<br>tems  | nne            | 11. Marital Status  |                         | 2. Was De<br>Armed F      | orces?                 |                  |                   | Was Dec<br>f Yes, sp    | edent of H<br>ecify Cuba | ispanic Ori<br>in, Mexicar | gin? (Spe<br>n, Puerto F | city Yes o<br>Rican, etc.               | )<br>)        |                    | ice - Ame<br>ack, White | ncan Indian,<br>e, etc.          |               |
| 2            | or i   | Y F            | Never Married 2☐ Mar  |                         | If Yes, G                 | 2 <b>∃t</b> No<br>Sive | )                |                   | 1 🗆 Yes                 | <b>2</b> √□ No           | Specify:                   |                          |   |               | Speci              | ity: W                  | hite                             |               |
| 0000<br>0000 | hours after<br>tural', or ite  | d by           | 3 Widowed 4 Divorced  |                         | Year or                   | Dates:                 |                  | 1                 |                         |                          |                            |                          |   |               |                    |                         |                                  |               |
|              | nat<br>den   | ete            | 15. Deceder<br>(Specify only highe  | it's Educa<br>ist grade | ation<br><i>completed</i> | ()                     |                  | 16a. Deced        | kind of w               | ork done                 | turina mos                 | t of workir              | ng                                      | 16            | b. Kind of E       | 3usiness/               | Industry                         |               |
| 2            | within 72<br>ene.<br>then "na  | mp             | Elementary/Secondary (0-12)   |                         | College                   | (1-4or 5+              | -}               |                   |                         | use retired              | ")                         |                          |   |               |                    |                         |                                  |               |
| N            | e filed within at Hygiene. Other than vent, to Me  | Completed      | 10  |                         |                           |                        |                  |                   | Barb                    | er                       |                            |                          | /F1                                     |               |                    | Hai                     | r                                |               |
| and          | De fizition of the first of the | Be             | 17. Father's Name (First, Middle,   |                         |                           |                        |                  |                   |                         |                          | 18. Mothe                  |                          |   | ddie, Ma      | iden Suma          | me)                     |                                  |               |
| <u>a</u>     |  | P              | Gabriele Petr   | ucce                    | 11i                       |                        |                  |                   |                         |                          |                            | Davi                     | dica                                    |               |                    |                         |                                  |               |
| Man          | and and summark  |                | 19a. Informant's Name/Relations   |                         | . ,                       |                        |                  | 19b. Mailir       | *                       |                          |                            |                          |   |               | -                  |                         |                                  |               |
|              | and 2  |                | Nicholas D.   | Petr                    | uccel                     | Lli/                   | Brot             | her l             | 3608                    | Darn                     | estow                      | m Ro                     | ad, I                                   | arn           | estow              | n, M                    | D 20878                          | 3             |
| Baltimore,   | ーエラティ  |                | 20a. Method of Disposition  | - ~-                    |                           |                        | 20b. Pla         | ace of Dispo      | sition (Nation)         | ame of other place       | (e)                        |                          | ate                                     | 20            | c. Location        | - City or               | Town, State                      |               |
| Ĕ            | Pages<br>nent of<br>ant: If it   |                | 1 ⊊ Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (5   |                         | moval fron                | n State                |                  | e of He           | -                       |                          | 1                          | July<br>200              | ۶ <sup>6</sup> ,                        | Si            | lver               | Spri                    | ng, Mai                          | brelv         |
|              | ertm<br>ortar<br>injui   |                | 21. Signature of Funeral Service  |                         | 9                         |                        | 1                |                   |                         |                          | 1                          |                          |   |               | Home               |                         | ng, na                           | yidha         |
| ñ            | permit. Depertr Importa any inju   |                | Daly Calley   | , M                     | 96Am                      |                        |                  |                   |                         |                          |                            |                          |   |               |                    |                         | g, Mđ 2                          | 20901         |
|              |  |                | 23a. Part1. Enter the disease, o  | r complic               | ations that               | caused t               | the death        |                   |                         | -                        |                            |                          |   |               |                    | PLIII                   | Approxima                        |               |
|              |  |                | shock, or heart failure. Lis-   | t only one              | cause on                  | each line              | ).               | . 201,010.        |                         | 340 U. U.                | 9, 0201. 20                | 04,4,40                  | · | .,            | •                  |                         | Interval Be<br>Onset and         | tween         |
| 2            | Physician  |                | Immediate Cause (Finel disease or condition resulting in death)   | _ a.                    | Acı                       | ıte M                  | lyoca            | rdial             | Inf                     | arcti                    | .on                        |                          |   |               |                    |                         | Immed                            | liate         |
|              | /Medical<br>Examiner   |                | resulting in death)   |                         | Due to                    | o (or as a             | consequ          | ence of):         |                         |                          |                            |                          |   |               |                    |                         |                                  |               |
| ٠.           | LAdimine   |                | Sequentially list sunditions.   | ь                       |                           |                        |                  | heros             | cler                    | osis                     |                            |                          |   |               |                    |                         | 5 yea                            | ars           |
| -            | D =  | ner            | E-quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | "                       | Due to                    | o (or as a             | consequ          | ence of):         |                         |                          |                            |                          |   |               |                    |                         |                                  |               |
|              | cuter<br>od<br>rans  | Examiner       | that initiated events   | c.                      |                           | perte                  |                  |                   |                         |                          |                            |                          |   |               |                    |                         | 10 ye                            | ears          |
| Ó            | an al  |                | resulting in death) Last  |                         | Due to                    | o (or as a             | consequ          | ence of):         |                         |                          |                            |                          |   |               |                    |                         |                                  |               |
| 8760         | death certificate be executed e attending physician and burial-transit of for use as the burial-transit  | dical          |   | d                       |                           |                        |                  |                   |                         |                          |                            |                          |   |               |                    |                         |                                  |               |
| 89           | tifica<br>ig ph<br>as th   | 0              |   |                         |                           |                        |                  |                   |                         |                          |                            | _                        |   |               |                    |                         |                                  |               |
| Box          | eath certific<br>attending p   | 2              | IF FEMALE:<br>23b. Was decedent pregnant  | 23                      | c. If yes, o              |                        |                  |                   | 7Catania                |                          |                            |                          |   |               | 23d. D             | ate of del              | livery                           |               |
| m            | deatl  | Cla            | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  |                         | 4∐Pre                     | ebirth 2<br>gnant at t |                  |                   | Other (                 | pregnancy<br>specify)    |                            |                          |   |               | N                  | lonth                   | Day                              | Year          |
| o.           | at the de<br>by the a<br>tached  | ys             | 9 🗆 Unknown   |                         | 9□ Unk                    | cnown                  |                  |                   |                         |                          |                            |                          |   |               |                    |                         |                                  |               |
| <u>a</u>     | The law requires that the site has been signed by the bage 2 should be detache   | by Physician/M | Part II. Other significant condit   | ions cont               | nbuting to                | death bu               | t not resu       | itting in the u   | nderlying               | cause giv                | en in Part I               |                          | 23e. [                                  | Did toba      | cco use co         | ntribute to             | the cause of                     | death?        |
| Records,     | sign<br>d be   |                | Hypercholester  | colem                   | nia                       |                        |                  |                   |                         |                          |                            |                          |   | Yes           | 2 🗆 No             | 3 🗆 Pr                  | robably 4                        | ]Unknown      |
| Ö            | w require<br>been si<br>should b   | Completed      | III) portonoros cor   |                         |                           |                        |                  |                   |                         |                          |                            |                          | 04: 1                                   |               |                    | 144                     | to to the                        |               |
| ě            | elaw<br>hasi<br>je 2 s   | ldu            |   |                         | -                         |                        |                  |                   |                         |                          |                            |                          | 1                                       | Mas an utopsy |                    | prior to death?         | utopsy findings<br>completion of | cause of      |
| _            |  | ç              |   |                         |                           |                        |                  |                   |                         |                          |                            |                          | 1 🗆 Y                                   | erforme       | No                 |                         | 2 □ No                           |               |
| Vital        | icien: Th<br>certificate<br>ector, pag   | Be             | 25. Was case referred to medical examiner?  | -                       |                           |                        |                  |                   |                         |                          |                            | e of Death               | (Check o                                | nly one)      |                    |                         |                                  |               |
| <b>-</b>     | Physic<br>this ca<br>al dire   | 2              | 1 ZYes 2 No   | H                       | ospital:                  | ] Inpatier             | nt 2 🗆 I         | ER/Outpatie       | nt 3 🗆 [                | DOA Oth                  | өг. 4□ №                   | ursing Hor               | ne <b>X</b>                             | Residen       | ce 6 □O            | ther (Spe               | cify)                            |               |
| 0            |  | ü              | 27. Manner of Death   | ine                     | 28a. Dat                  | e of Injur             | Year)            | 28b. Time o       | f                       | 28c. Injur<br>Wor        | y at<br>k?                 | 4                        | 28d. Desc                               | nbe how       | injury occu        | ırred                   |                                  |               |
| ō            | ath.<br>r: Af<br>e fur   | atlo           | 1 Natural 5 Pendi<br>2 Accident invest  | tigation                |                           |                        |                  | ,,,,,             | М                       |                          | Yes 2□                     | No                       |   |               |                    |                         |                                  |               |
| Division of  |  | 150            | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide deten   | not be<br>mined         | 28e. Pla                  | ce of Inju             | ry - At ho       | me, farm, st      | reet, facto             | ory, office              |                            | 2                        |   |               |                    | ber or Ri               | ural Route Nu                    | mber,         |
| á            | 5 # 5 E  | Certification; | 4 [] Homicide   |                         | БШ                        | tding, etc.            | . (Зреспу        | ')                |                         |                          |                            |                          | City O                                  | Town,         | State)             |                         |                                  |               |
|              | spite  |                | 29a. Certifier 1 🖫 Kertifyi   | ing Phys                | ician: To t               | the best o             | f my knov        | wledge, deat      | h occurre               | d at the tir             | ne, date ar                | nd place, a              | and due to                              | the cau       | se(s) and n        | nanner as               | s stated.                        |               |
|              | To the Hospitel or within 24 hours afte To the Funerel Dir. completely filled in   | Medical        | (Check only 2 Medica one)   | I Examin                | er: On the<br>and ma      | basis of anner stat    | examinat<br>ted. | ion and/or in     | vestigatio              | on, in my o              | pinion, dea                | ath occurre              | ed at the t                             | me, date      | and place          | , and due               | e to the cause                   | (s)           |
|              | of thing of the office of the  | Me             | 29b. Signature and title of certifi   | er                      | Λ                         | 0/                     | 12               | 41/               | 7                       | 9c. Licens               | e number                   |                          |   | 290           | I. Date sign       | ed (Mont                | h, Day, Year)                    |               |
|              |  |                |   | 18                      | 11                        | //                     | 1                | 1/1               | 1/                      | DO                       | 01192                      | 2                        |   |               |                    | July                    | 5, 20                            | 06            |
|              | 9  |                | 7   | 1                       | vu                        | 6                      | 201              | 1011              | 2/2                     |                          |                            |                          | -                                       |               |                    |                         |                                  |               |
|              |  |                | 30. Name and address of pelson  | /                       |                           |                        |                  |                   |                         | 024                      | #1 x                       | Ro+h                     | e Frage                                 | MD            | 2021               | 4                       |                                  |               |
| art.         | g86 5- 1076 <b>p.</b>  |                | John Galot  |                         |                           | Registra               | r's Signal       | Ura -             |                         | .oau,                    | TTA,                       | De CI                    | Losud                                   | עוניו ק       | 2001               |                         |                                  |               |
| 1            | St<br>Regist   | ate<br>rar     | JUE O   |                         | ADP                       | PRAR                   | , J              | ture              | We !                    |                          |                            |                          |   |               |                    |                         |                                  |               |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2807 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WILLIAM DONAHUE **POWELL** 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital 7. Age (In yrs. last birthday) Hagerstown If Under 1 Year | If Under 24 Hrs. Washington County 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 220-54-2892 1⊠M 2□ F Months Hours 55 July 17, 1950 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits

10f. Zip Code

July 1975
16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

21742

Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

P.O. Box 491 Funkstown, Maryland

Hagerstown

Nov.1968 1 Yes 25 No

Specialist

20b. Place of Disposition (Name of cemetery, crematory or other place,

12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No If Yes, Give Year or Dates:

College (1-4or 5+)

1 ☐ Yes 2 🖫 No

10g. Citizen of What Country?

U.S.A.

Specify:

18. Mother's Name (First, Middle, Maiden Sumame)

Ruth Augusta Thomas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

16b. Kind of Business/Industry

21734

20c. Location - City or Town, State

14. Race - American Indian, Black, White, etc.

Federal Government

White

with the Maryland ns 23a or 2 deeth Baltimore, Maryland 21215-0036 ö f Health a item 27 i 1 - State Registrar

10a. State

10e. Street and Number

11. Marital Status

14014 Marsh Pike

1 ☐ Never Married 2 ☑ Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

Richard Donahue Powell

19a. Informant's Name/Relationship (Type, Print)

Amy L. Miller / Daughter

1 Burial 2 Cremation 3 Removal from State

Direct

δ

Completed

Be

Maryland Washington County

15. Decedent's Education (Specify only highest grade completed)

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Phys /Me Exar

Division of Vital Records, P.O. Box 68760,

|  | 4 ☐ Donation 5 ☐ Other (Specify)   | Rest Haven Cemetery July  | 14, 2006 Hagerst   | town, Maryland   |
|--|--|---|--|--|
| Medical Certification: To Be Completed by Physician/Medical Examiner | 21 Signature of Funeral Service Licensee                                       | 22. Name and Address of Facility  | ıglas A. Fiery Fu  | neral Home   |
|  | shock, or hear railure. List only one cause on each                            | sed the death. Do not enter the mode of dying, such as cardiac hine.  | or respiratory arrest,   | Approximate<br>Interval Between<br>Onset and Death     |
|  | Immediate Cause (Final disease or condition resulting in death)                | Anoxie brown injury   |  | 24 lns   |
| r  | Sequentially list conditions b   | as a consequence of):  Cardia Milmoneny avi as a consequence of):   | rest   | 24 hrs.  |
| xamine   | cause. Enter Underlying Cause (Disease or injury that initiated events  c      | 15 chemie heart & se as a consequence of):  | ease   | Jeens  |
| dicai E  | d  | Drahelese mellitus  |  | years.   |
| ıysician/Me  |  | n 2 ☐ Fetal death 3 ☐ Ectopic pregnancy<br>t at time of death 5 ☐ Other (specify)   | 23d. Date of o   | delivery<br>Day Year                                   |
| þ  | Part II. Other significant conditions contributing to death                    | but not resulting in the underlying cause given in Part I.  | 23e. Did tobacco use contribute  1 Yes 2 No 3                                | e to the cause of death?  Probably 4 (Anknown)         |
| ompiet   | Hyperfer Des i Mas a l   | L Vaxela Mease  | performed? death   | autopsy findings available to completion of cause of ? |
| 0  | 25. Was case referred to medical examiner?                                     |   | th (Check only one)  |  |
| 0  |  | atient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho  | ome 5 Residence 6 Other (S   | pecify)  |
| atlon:   | 2 Accident investigation   | Injury Day Year) 28b. Time of Injury Work? 1 ☐ Yes 2 ☐ No   | 28d. Describe how injury occurred  |  |
| Sertific   | 3 Suicide 6 Could not be determined 28e. Place of building,                    | Injury - At home, farm, street, factory, office, etc. (Specify)   | 28f. Location (Street and Number or<br>City or Town, State)                  | Rural Route Number,                                    |
|  | 29a. Certifier (Check only one)  29a Medical Examiner: On the basis and manner | est of my knowledge, death occurred at the time, date and place, is of examination and/or investigation, in my opinion, death occur r stated. | and due to the cause(s) and manner<br>red at the time, date and place, and c | as stated.<br>due to the cause(s)                      |
| Me   | 29b. Signature and title of certifier  | 29c. License number   | 36 July 11   | onth, Day, Year)                                       |
|  | 30. Name and address of person who completed cause of                          | of death (Item 23a) (Type, Print)  (ND 20311 Lappans  | Rd Boonsbor  | 0 MD21713  |

State Registrar

31. Date filed (Month, Day, Year) JUL 12 2006

32. Registrar's Signature Sperker

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Milford 330 **Physician** 2006 Pett: JUly a M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hospital Berlin Worchester General If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 □ F 49 215-62-0163 Director 1956 VICGINIA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 X No Funerai Director Maryland Worcester Ocean City 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code rthen "natural", or Itams 23a or the Medical Examinar must be r USA 13 Dockside Road 21842 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 XNever Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Be Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Freelance fish cleaner Seafood 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Louise Marie Pettit John Edward Fooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21842 Health a Mr. Peter Harker/friend Sunset Marina, 12911 Sunset Avenue, Ocean City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department o Importent: If any injury or 07/08/2006 Berlin, Maryland New Bethel C. Cem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD 21. Signature of Funeral Service Licenses 21801 JOLLEY MEMORIAL CHAPEL 23a. Part1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Renal one month Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Vital Hospital or Attanding Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA ō 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred lon n X Natural 2 ☐ Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DGO63641 3 Frank Guarniegi, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 733 9 Ho.spital Healthway General 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

0160110 -

GOD

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DOB

|            |  |                  | 1 - For<br>State<br>Registrar   | State of  | Marylar                                 |                                  |                                  |                     | lealth a<br>Death          | and Me                     |   | jiene                       | 2006                                | 2280                            |
|------------|--|------------------|---|---|---|----------------------------------|----------------------------------|---------------------|----------------------------|----------------------------|---|-----------------------------|-------------------------------------|---------------------------------|
|            |  |                  | 1. Decedent's Name (First, Middle, La   | ast)  |   |                                  |                                  |                     |                            | 2                          | 2. Date of Dea                            | th                          | .,                                  | 3. Time of Death                |
|            | Physic<br>/Medi  |                  | Daisey Lee Pinda  | r   |   |                                  |                                  |                     |                            |                            | Month 7                                   | OI                          | 2006                                | 1102 AM                         |
|            | Examir   |                  | 4a. Facility Name (If not institution, gir                                    | e street and numb                                       | er)                                     |                                  | 4b. City                         | , Town, or          | Location o                 | of Death                   |   |                             | unty of Death                       |                                 |
| 1          |  |                  | PENINSUM REGIONAL   | Medical   | Con                                     | HR                               |                                  | 340                 | 13641                      | 14                         |   | 1                           | consco                              | )                               |
|            | Funeral<br>Director  |                  |   |   | Age (In yrs.                            | last birthday)<br>Yrs.           | Months                           | Days                | If Under a                 | Min.                       | B. Date of Birth<br>(Month, Day<br>Feb 26 | , Year)                     | Count                               |                                 |
|            | and w  |                  | Usual Residence of Decedent  10a. State 10b. County                           |   | 10c. Cit                                | ty, Town or Le                   | ocation                          |                     |                            |                            |   |                             | 10                                  | Od. Inside City Limits          |
|            | Manyl<br>f eho   | jo               | MD Wicomi   | co  |   | alisbu                           |                                  |                     |                            |                            |   |                             |                                     | Yos 2 □ No                      |
|            | r 28a  | Irec             | 10e. Street and Number  |   |   |                                  | 10f. Z                           | ip Code             |                            |                            | 1   | 0g. Citizen                 | of What Count                       | try?                            |
|            | h wit  | a D              | 1015B Marine Rd.  |   |   |                                  | 2                                | 1801                |                            |                            |   | USA                         | 4                                   |                                 |
|            | lteme :  | Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☐ Married                              | 12. Was Decede<br>Armed Force<br>1 ☐ Yes 2              | es?                                     | I.S. 13.                         | Was Dec                          | edent of H          | spanic Orig<br>n, Mexican  | gin? (Speci<br>, Puerto Ri | fy Yes or No-<br>can, etc.)               | 14.                         | Race - America<br>Black, White, e   | itc.                            |
| 21215-0036 | ges 1 and 2 should be filed within 72 hours atter death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28s-f show or other treumatic event, the Medical Evantical for neitled at | by               | 3 Widowed 4 N Divorced  | If Yes, Give<br>Year or Date                            |   |                                  | 1 🗆 Yes                          | 2 <b>₹</b> No       | Specify:                   |                            |   | Sp                          | ecity: Blac                         | ck                              |
| 15-(       | in 72 h<br>n "natu<br>Medica   | Completed        | 15. Decedent's E<br>(Specify only highest gr                                  | ade completed)  |   | 16a. Dece<br>(Give<br>life.      | dent's Us<br>kind of w<br>DO NOT | ork done o          | lurina most                | of working                 | ,   | 16b. Kind                   | of Business/Ind                     | ustry                           |
| 212        | d with<br>giene.   | mo               | Elementary/Secondary (0-12)   | College (1-4  | or 5+)                                  |                                  |                                  | lerk                |                            |                            |   | E                           | Banking                             |                                 |
| pu         | permit. Pages 1 and 2 should be filed 'Department of Health and Mental Hygi Important: If Item 27 is marked other important of other traumatic event, any injury or other traumatic event, ang.  | BeC              | 17. Father's Name (First, Middle, Las.  | )   |   |                                  |                                  |                     | 18. Mother                 | r's Name (i                | First, Middle,                            | Maiden Sur                  | тате)                               |                                 |
| Maryland   | should be fand Mental I  | 2                | Willie Rogers   |   |   |                                  |                                  |                     |                            |                            | Beasley                                   | -                           |                                     |                                 |
| Nar        | 12 sh<br>h and<br>h and<br>T is rr   |                  | 19a. Informant's Name/Relationship  |   |   |                                  |                                  |                     |                            |                            |   |                             | wn, State, Zip (                    | Code)                           |
|            | i and<br>Healt<br>em 2   |                  | Sharonda Pindar/o   | daughter  | 20b. F                                  | Place of Disno                   | osition /Na                      | me of               |                            | Salisk                     | oury, M                                   |                             | 301<br>ion - City or Tov            | un State                        |
| Baltimore, | ages<br>int of<br>t: If it   |                  | 1 ☑ Burial 2 ☐ Cremation 3 [  |   | ate C                                   | cemetery, cre                    | matory or                        | other plac          |                            |                            |   |                             | •                                   |                                 |
| Ħ          | artme<br>ortan<br>injur  |                  | 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral) Service Lice            |   | GLE                                     | en Acı                           | -                                |                     | s of Facility              | 7/7/20<br>v                | 000                                       | Same                        | sbury, M                            | رات<br>ا                        |
| B          | permit. Departr Imports any inju   |                  | > 1/1×1   |   |   | Le                               | ewis                             | N. Wa               | atson                      | Funer                      | ral Hom                                   |                             | 001                                 |                                 |
|            |  |                  | 23a. Part Enter the diseas t, or con shock, or heart failure. List only       | one cause on eac  | sed the deat                            | th. Do not en                    | ter the mo                       | de of dyin          | g, such as o               | cardiac or r               | OUTY, N                                   | est,                        |                                     | Approximate<br>Interval Between |
| 100        | Physician  |                  | Immediate Cause (Final disease or condition                                   | Co  | PD                                      | )                                |                                  |                     |                            |                            |   |                             |                                     | Onset and Death                 |
|            | /Medical<br>Examiner   |                  | resulting in death)   | Due to (or  | as a conseq                             | quence of):                      |                                  |                     |                            |                            |   |                             |                                     |                                 |
|            | Lxammer  | _                | Sequentially list conditions,   | b. Due to /or   | as a conseq                             |                                  |                                  |                     |                            |                            |   |                             |                                     |                                 |
|            | nsit   | Examiner         | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 10) 01 600  | as a conseq                             | (uerice or):                     |                                  |                     |                            |                            |   |                             |                                     |                                 |
| Ć.         | death certificate be executed<br>e attending physicien and<br>of for use es the burial-transit   | Ехаг             | that initiated events<br>resulting in death) Last                             | C. Due to (or   | as a conseq                             | quence of):                      |                                  |                     |                            |                            |   |                             |                                     |                                 |
| 8760,      | ysicie   | dical            | (   | _ d   |   |                                  |                                  |                     |                            |                            |   |                             |                                     |                                 |
| 9          | ng ph  | Medi             | IF FEMALE:  |   |   |                                  |                                  |                     |                            | _                          |   |                             |                                     |                                 |
| Box        | death certitics<br>attending pl  | an/              | 23b. Was decedent pregnant in the past 12 months?                             | 23c. If yes, outco                                      | me of pregna<br>n 2 ☐ Feta              |                                  | ⊒Ectopic p                       | regnancy            |                            |                            |   | 23d.                        | Date of deliver                     | •                               |
|            | the at   | Physician/Me     | 1 Yes 2 No  | 4□Pregnan<br>9□Unknow                                   | it at time of d                         | leath 5                          | Other (s                         | pecify)             |                            |                            |   |                             | Month E                             | Day Year                        |
| P.0        | res that the de<br>igned by the a<br>be detached t   |                  | Part II. Other significant conditions   | contributing to deat                                    | h but not res                           | sulting in the u                 | ınderiying                       | cause give          | n in Part I.               |                            | 23e. Did tol                              | pacco use o                 | contribute to the                   | cause of death?                 |
| Records,   | sign<br>d be   | Completed by     | SIP Larygeal  |   |   |                                  |                                  |                     |                            |                            | 1 <b>/2</b> (Ye                           | s 2 N                       | o 3 Proba                           | bly 4 Unknown                   |
| S          | s been<br>s been<br>shoul  | slete            | ·   |   |   |                                  |                                  |                     |                            |                            | 24a. Was a                                | n 24                        | 4b. Were autop:                     | sy findings available           |
| Re         | The law<br>sete hes<br>page 2 :  | E                |   |   |   |                                  |                                  |                     |                            |                            | autops                                    | ned?                        | prior to com<br>death?              | pletion of cause of             |
| of Vital   |  | 0                | 25. Was case referred to medical  |   |   |                                  |                                  |                     | 26. Place                  | of Death (0                | 1 ☐ Yes<br>Check only on                  | No No                       | 1 ☐ Yes 2                           | 2 □ No                          |
| <b>†</b>   | S D  | To B             | examiner?<br>1 ☐ Yes 2 XNo  | Hospital: 1 ☐ Inp                                       | atient 2                                | (ER/Outpatier                    | nt 3 D                           | OA Othe             |                            |                            |   |                             | Other (Specify)                     |                                 |
| 0          | ng Pt  |                  | 27. Manner of Death 1 Natural 5 ☐ Pending                                     | 28a. Date of (Month,                                    | njury<br>Day Year)                      | 28b. Time o<br>Injury            | of                               | 28c. Injury<br>Work |                            |                            | d. Describe ho                            |                             |                                     |                                 |
| sio        | uttendii<br>death.<br>ctor: A<br>y the fu  | cati             | 2 Accident investigation 3 Suicide 6 Could not to                             | NO.   |   |                                  | М                                | 10`                 | res 2 □ N                  | No                         |   |                             |                                     |                                 |
| Division   | if or Attending<br>efter death.<br>I Director: Attend<br>d in by the fune  | Certification:   | 4 Homicide determined   | 286. Place of   | Injury - At ho<br>, etc. <i>(Specif</i> | ome, farm, sti<br>fy)            | reet, factor                     | y, office           |                            | 28                         | f. Location (St<br>City or Town           | reet and Nu<br>n, State)    | umber or Rural                      | Route Number,                   |
|            | To the Hospital or Attending Ph<br>within 24 hours effer death.<br>To the Funeral Director: Atter th<br>completely tilled in by the funeral  | Medical          | 29a. Certifying P<br>(Check only 2 Medical Exa                                | hysician: To the be<br>miner: On the basi<br>and manner | s of examina                            | owledge, deat<br>ation and/or in | h occurred<br>vestigation        | at the tim          | e, date and<br>inion, deat | d place, and<br>h occurred | d due to the ca<br>at the time, da        | ause(s) and<br>ate and plac | I manner as sta<br>ce, and due to t | led.<br>the cause(s)            |
|            | To the To the Comp   | ž                | 29b. Signature and title of certifier   |   |   |                                  | }                                | c. License          |                            |                            | 1   | 9d. Date sig                | gned (Month, D                      | ay, Year)                       |
|            | 1000   |                  | Y'aul R. He   | my M  |   |                                  |                                  | 024                 | 487                        | 2                          |   | 7/2                         | 106                                 |                                 |
| 7          | gliss  |                  | 30. Name and address of person who  |   | of death (Item                          |                                  | Print)                           | or m.               | 487<br>Loke                | Cath                       | 14 (1)                                    | 2100                        | -,                                  |                                 |
|            | Sta  | ate              | 31. Date filed (Month, Day, Year)   | 32. R   | istrar's Signa                          |                                  | ,                                | - CU P              |                            |                            |   | 2183                        | /                                   |                                 |
|            | Regist   | rar              | JUL U 5   | 2006  | 100                                     | le .                             | 1                                |                     |                            |                            |   |                             |                                     |                                 |

|            |  |                  | For<br>State<br>Registrar  | State of Maryla   |                                      |  | of Health and<br>of Death   | -  | Mental Hygiene 2006 2281        |   |                         |  |  |
|------------|--|------------------|--|---|--------------------------------------|--|---|--|---------------------------------|---|-------------------------|--|--|
|            | Physici<br>/Medic  |                  | 1. Decedent's Name (First, Middle, Las.<br>Frederick   | Parki   | inson S                              | sr.  |   | 2. Date of De<br>Month                               |                                 | Year .  | me of Death             |  |  |
|            | Examin Funeral Director  |                  | 4a. Facility Name (If not institution, give following following) 5. Social Security Number 6. Security Number 110  | Mesinge C.  | EWPEX<br>irs. last birthday)<br>Yrs. | If Under 1 Y   | m, or Location of De<br>SAUSGUA<br>ear If Under 24<br>ays Hours M | rs. 8. Date of Bir                                   | th<br>iy, Year)                 | of Death    Com   Co  9. Birthplace (S. Country)                | tate or Foreign         |  |  |
|            | D  | tor              | Usual Residence of Decedent 10a. State 10b. County Maryland Somerse  | 10c.  | City, Town or Lo                     | ocation<br>ss Anne   |   | 10/8/1   | .925                            |   | de City Limits Yes 2 No |  |  |
|            | h with the<br>23a or 28a<br>at be not  | Funeral Director | 10e. Street and Number<br>26914 Mt. Vernon   |   | 211100                               | 10f. Zip Cod   |   |  | 10g. Citizen of W               | /hat Country?   |                         |  |  |
| 920        | s 1 end 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at | 출                | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | 12. Was Decedent Ever in Armed Forces?  1 X Yes 2 □ No If Yes, Give Na Year or Dates: | vy 13.                               | Was Decedent<br>If Yes, specify (<br>1 ☐ Yes 2 🔀             | Cuban, Mexican, Pu  | (Specify Yes or No<br>ento Rican, etc.)              | Black                           | e - American India<br>k, White, etc.<br>White                   | in,                     |  |  |
| 21215-0036 | d within 72 ho<br>jiene.<br>ir then "natur<br>ir e Medicel   | Completed        | 15. Decedent's Ed<br>(Specify only highest grad<br>Elementary/Secondary (0-12)   | ucation<br>de completed)<br>College (1-4or 5+)  | (Give                                | dent's Usual Oc<br>kind of work do<br>DO NOT use re<br>inter | one during most of v  | working  | 16b. Kind of Bu                 | siness/Industry   |                         |  |  |
| Maryland ; | 2 should be filed withlic<br>and Mental Hygiene.<br>is marked other then<br>aumatic event, the Mi  | To Be C          | 17. Father's Name (First, Middle, Last) John Parkinson   |   |                                      |  |   | Name (First, Middle,<br>Lah White                    |                                 |   |                         |  |  |
|            | 1 end 2 sh<br>Health and<br>Iem 27 is m  |                  | 19a. Informant's Name/Relationship (7) Phyllis Parkinson 20a. Method of Disposition  | n/wife  |                                      | 914 Mt.  | Vernon F  | Rural Route Number Rd., Prince Date                  | cess Anne                       |   | 853                     |  |  |
| altimore,  | Page<br>nent c<br>ant: if<br>ury or  |                  | 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,  | Removal from State  | cemetery, crer<br>Salisbur           | y Crema  | tory 7/   | 05/06  | Salisb                          | ury, MD   |                         |  |  |
| Ba         | permit. Depertriments imports eny interes  |                  | 23a. Part1. Enter the disease, or comp   | lications that caused the de  | ار ا                                 | OT DITOM   | min Ka.   | Home Prof  | ary, MD a                       | l Associ<br>21804<br>Approx                                     |                         |  |  |
| 1          | Physician<br>/Medical<br>Examiner  | -er              | shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate | a. Due to (or as a cons   | sequence of):                        | r diss   | <b>E9)</b> 8  |  |                                 | Interva<br>Onset  | al Between<br>and Death |  |  |
| 8760,      | cate be executed<br>physicien and<br>the burial-transit  | dical Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last       | c   |                                      |  |   |  |                                 |   |                         |  |  |
| P.O. Box 6 | The law requires thet the death certificate be executed the hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit   | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown   | 23c. If yes, outcome of pre<br>1 Live birth 2 F<br>4 Pregnant at time o<br>9 Unknown  | etal death 3                         | Ectopic pregna<br>Other (specify                             |   |  | 23d. Date<br>Mon                | of delivery<br>th Day   | Year                    |  |  |
| Records, P | w requires thet<br>been signed b<br>should be deta   | 5                | Part II. Other significant conditions co   | ntributing to death but not r   | resulting in the u                   | nderlying cause  | given in Part I.  |  | obacco use contri               |   | of death?               |  |  |
| Vital Rec  |  | e Completed      | 25. Was case referred to medical   |   |                                      |  |   | 1 ☐ Yes  | osy pr<br>rmed? de<br>2. No 1 ( | /ere autopsy find<br>rior to completion<br>eath?<br>☐ Yes 2☐ No |                         |  |  |
| ō          | Phys<br>this<br>rai dii  | ToB              | examiner?  | Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)                        | ER/Outpatien 28b. Time of Injury     | 28c. I   | Other   | Death (Check only of Home 5 Residue)  28d Describe h |                                 |   |                         |  |  |
| Division   | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral  | Certification:   | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of Injury - Al<br>building, etc. (Spe                                      | ecify)                               |  |   | City or Tov  | ŕ                               |   | Number,                 |  |  |
|            | the Hosp<br>in 24 hou<br>the Fune<br>npletely fil  | Aedical          | one)   | rsician: To the best of my kiner: On the basis of examinand manner stated.            | ination and/or inv                   | vestigation, in r  | ny opinion, death oc  | curred at the time,                                  | date and place, ar              | nd due to the cau   |                         |  |  |
|            | S S S S S S S S S S S S S S S S S S S  | W                | 29b. Signature and title of certifier  | ompleted cause of death (III  |                                      | 29c. Lie   | 954807  |  | 29d. Date signed 7-01           | (Month, Day, Yes  | ar)                     |  |  |
| 1          | 0,74   |                  | 30. Name and address of person who can RAMEESH AGAYWAL   | ompleted cause of death (II   | tem 23a) (Type,                      | Print) 611 51.   | SALISBU   | ry MD  |                                 |   |                         |  |  |
|            | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)  JUL 0 5 2   | 32. Registrar's Sig   | gnature                              | nouth 1  |   |  |                                 |   |                         |  |  |

filed within 72 hours after death with the Maryland

Hygiene.

ould be fi

and

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician:

death.

1 - State Registrar

**Physician** 

1. Decedent's Name (First, Middle, Last)

Annie

Mae

Plutschak

5:00 pм July 9 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 4619 Gadow Road Preston Caroline If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 1 X F 69 Yrs. 214-34-8688 Director April 4, 1937 Georgia Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Be Completed by Funeral Director MD Caroline Preston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 4619 Gadow Road 21655 or Itams 23a United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2√□ No If Yes, Give Year or Dates: 1 □ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 □ Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William McDonald marked Fannie Mae Wood 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health itam 27 i 4619 Gadow Rd., Preston, Gerald Plutschak/Spouse MD 21655 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its any injury or ot 1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State Junior Order Cem. 07/12/06 Preston, Maryland <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A 21. Signature of Funeral Service Licensee Zskow 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 Ho 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 10 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: Other 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ M6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t determined 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. e of certifier 29b. Signature and t 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29466 Pintail Dr., Easton, MD 21601 David Smith, M.D Dr. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

Time of Death

Registrar

2006

|             |  |                     | 1 - For<br>State<br>Registrar   | State of Ma  | aryland /       |                      | artment<br>tificate         |                                 |                         | d Me                                   |                   | giene<br>Reg. No. | 200                     | 6 2                         | 2812                          |
|-------------|--|---------------------|---|--|-----------------|----------------------|-----------------------------|---------------------------------|-------------------------|--|-------------------|-------------------|-------------------------|-----------------------------|-------------------------------|
|             | Physicia   |                     | 1. Decedent's Name (First, Middle, I  |  |                 |                      |                             |                                 |                         | 2.                                     | Date of Dea       |                   | Year                    |                             | e of Death                    |
|             | /Medic   |                     | LOUIS K   | HJSHTG   | 160             |                      | e.                          |                                 |                         |  | JUNE              |                   | 5 20                    | 068.                        | 35 Am                         |
|             | Examin   | er                  | 4a. Facility Name (If not institution, g  |  |                 |                      | 4b. City, To                | own, or Lo                      | ocation of De           | eath                                   |                   |                   | County of Dec           |                             |                               |
| ŀ           |  |                     |   |  | (In yrs. last   | hirthday)            | If Under 1                  | Year II                         | f Under 24 F            | Irs. 8                                 | Date of Birt      | -                 | 0.0                     |                             | te or Foreign                 |
|             | Funeral<br>Director  |                     | 578.36.0188   | 1\mathbb{M} 2□F                                    | 76              | Yrs.                 | Months                      | Days                            | Hours M                 | lin.<br>Fe                             | Month, Day        | 7. Year)<br>193   | 0 Wa                    | shingt                      | te or Foreign                 |
|             | D  |                     | Usual Residence of Decedent   |  |                 |                      |                             |                                 |                         |  |                   |                   |                         |                             |                               |
|             | nylan<br>bow   |                     | 10a. State 10b. County  |  | 10c. City, T    |                      |                             |                                 |                         |  |                   |                   |                         |                             | City Limits                   |
|             | 8e-1   | cto                 | DC  |  |                 | Wash                 | ingto                       |                                 |                         |  |                   |                   |                         |                             | res 2∏No                      |
|             | with the   | 盲                   | 10e. Street and Number 3025 Cleveland   | l Avenue. N.                                       | W.              |                      | 10f. Zip C                  | 3008                            |                         |  |                   | 10g. Citiz        | uen of What C           | _                           |                               |
|             | ns 23  | erai                | 11. Marital Status  | 12. Was Decedent E                                 |                 | 13. V                |                             |                                 | anic Origin?            | (Specif                                | y Yes or No-      | . 1               | I4. Race - Am           |                             | 1.                            |
| 020         | s 1 end 2 should be filed within 72 hours after deeth with the Maryland if Heetih and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23s or 28e-f show other treumstic event, the Medical Examinationships | by Funeral Director | 1 Never Married 2 Married 3 Widowed 4 Divorced  | Armed Forces?                                      |                 | 11                   | fYes, specif                | y Cuban, I                      | Mexican, Pu<br>Specify: | ièrto Ric                              | ean, etc.)        |                   | Black, Wh               |                             |                               |
| 5           | 72 ho  | Completed           | 15. Decedent's (Specify only highest of   | Education  | 1               | 6a. Deced            | ient's Usual                | Occupation                      | on<br>ina most of i     | workina                                |                   | 16b. Kir          | nd of Busines           | s/Industry                  |                               |
| V           | ithin 7  | npie                | Elementary/Secondary (0-12)   | College (1-4or 5                                   | +)              |                      | kind of work<br>DO NOT use  | retired)                        | ang most or t           | ···O·································· |                   |                   |                         |                             |                               |
| V           | ygien<br>ygien<br>ygien<br>tt, ne  |                     |   |  | -               | Journ                | alist                       |                                 | - 11-15-1-1             |  |                   |                   | epende:                 | nt                          |                               |
|             | be fill H dot  | Be                  | 17. Father's Name (First, Middle, La  |  |                 |                      |                             | 18                              |                         |  | First, Middle,    |                   | Sumame)                 |                             |                               |
| Ž           | d Mental<br>marked c   | ဥ                   | 19a. Informant's Name/Relationship  | hschild, Sr  |                 | 10b Mailin           | a Address (                 | Stroot and                      |                         |  | Cohe              |                   | Town, State,            | Zie Codel                   |                               |
| 2           | d 2 sh<br>th and<br>th and<br>t7 is m<br>treum   |                     | Sonia Rothschil   |  |                 |                      | Cleve1                      |                                 |                         |  |                   | 2000              |                         | ZIP COde)                   |                               |
| D,          | tem 2  |                     | 20a. Method of Disposition  |  | 20b. Place      | e of Dispo           | sition (Name                | of                              |                         | Date                                   |                   |                   | cation - City o         | r Town, State               |                               |
| 2           | Page<br>ont of   |                     | 1 ☐ Burial 2 【 Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spe   |  | 1               | -                    | natory or oth<br>Cremat     |                                 | 6/                      | /30/                                   | 06                | Fa11:             | s Churc                 | ch. VA                      |                               |
| Dallino     | permit. Pages 'Department of Himportant: If Ite any Injury or ot once.   |                     | 21. Signature of Funeral Service Lie  |  |                 | 22                   | . Name and                  | Address                         |                         |  | h Gaw             | ler's             | s Sons                  | Inc.                        |                               |
|             |  |                     | 23a, Part 1, Enter the disease, or co   | omplications that caused                           | the death. I    |                      |                             |                                 |                         |  |                   |                   | 3010                    | Approxi                     | mate                          |
|             |  |                     | 23a. Part 1. Enter the disease, or co<br>shock, or heart failure. List or<br>Immediate Cause (Final         | ly one cause on each lin                           | 10.             |                      | 1 1                         |                                 |                         |  |                   |                   |                         | Interval                    | Between<br>nd Death           |
| à           | Physician<br>/Medical  |                     | disease or condition resulting in death)  | a. END   | STA             | 68                   | De                          | me                              | NTI                     | 4                                      |                   |                   |                         | yea                         | rs_                           |
|             | Examiner   |                     | 1   | Due to (or as                                      | a consequen     | Ce or):              |                             |                                 |                         |  |                   |                   |                         | /                           |                               |
|             | 4  | er                  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as                                   | a consequen     | ce of):              |                             |                                 |                         |  |                   |                   |                         |                             |                               |
|             | cuted  | Examiner            | that initiated events   | c  |                 |                      |                             |                                 |                         |  |                   |                   |                         |                             |                               |
| Š           | e exe<br>len ar<br>urial-t   | EX                  | resulting in death) Last  | Due to (or as                                      | a consequen     | ce of):              |                             |                                 |                         |  |                   |                   |                         |                             |                               |
| 8/00,       | certificate be executed iding physicien and ise as the burial-transit  | dical               |   | d  |                 |                      |                             |                                 |                         |  |                   |                   |                         |                             |                               |
| 0<br>X<br>0 | ding p   | /Me                 | IF FEMALE:  | 23c. If yes, outcome                               | of pregnancy    | ,                    |                             |                                 |                         |  |                   |                   |                         |                             |                               |
| 00.         | w requires that the death certificate be executed<br>been signed by the ettending physicien and<br>should be deteched for use as the buriat-transit  | Physician/Me        | 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No  | 1 ☐ Live birth<br>4 ☐ Pregnant at                  | 2 Fetal de      | ath 3                | Ectopic preg<br>Other (spec |                                 |                         |  |                   | 2                 | 3d. Date of de<br>Month | Day                         | Year                          |
| 5           | requires that the<br>een signed by th<br>nould be deteche  | hys                 | 9 Unknown   | 9□ Unknown   |                 |                      |                             |                                 |                         |  |                   |                   |                         |                             |                               |
| 'n          | es tha   | þ                   | Part II. Other significant condition  | s contributing to death be                         | ut not resultin | ng in the ur         | nderlying cau               | ıse given i                     | in Part I.              | į                                      |                   |                   | se contribute           |                             |                               |
| 202         | requir<br>een s  | ted                 |   |  |                 |                      |                             |                                 |                         | -                                      | 1 🗆 Y             | es 25             | No 3□F                  | robably 4                   | Unknown                       |
| Š           | The law ste hes boage 2 sh   | Completed           |   |  |                 |                      |                             |                                 |                         | _                                      | 24a. Was<br>autop | sy                | prior to                | utopsy findin<br>completion | gs available<br>of cause of   |
| ומו         | w  |                     |   |  |                 |                      |                             |                                 |                         |  | perfor            | 2000              | death?<br>1 ☐ Ye        | s 2 No                      |                               |
|             | Physician: The this certificete rat director, pag  | Be                  | 25. Was case referred to medical examiner?  | Hospital:  |                 |                      |                             | 1 0.4                           | -                       |  | Check only o      |                   |                         |                             |                               |
| ō           | ding Physician:<br>h.<br>After this certific<br>funeral director,  | 2                   | 1 Yes 2 No 27. Manner of Death  | 28a. Date of Injur                                 | v 28            | Outpatien b. Time of | t 3 DOA                     |                                 |                         |  | 5 Resid           |                   | Other (Sp.              | ecify)                      |                               |
|             | ding<br>th.<br>Afte<br>fune  | ertification;       | 1 Accident 5 Pending investigat   | (Month, Da)  | Year)           | Injury               | м                           | c. Injury at<br>Work?<br>1  Yes | s 2 No                  |  |                   | ,,,,,             |                         |                             |                               |
| VISION      | Atter<br>r dea<br>ector<br>by the  | ifica               | 3 Suicide 6 Could no  | ad 286. Place of Inju                              | ury - At home   | , farm, str          | eet, factory,               | office                          |                         | 28f                                    |                   |                   | Number or F             | lural Route N               | lumber,                       |
| 5           | s afte   | Cert                | 4   Nomicide  | building, etc                                      | . (Specily)     |                      |                             |                                 |                         |  | City or Tow       | m, State)         |                         |                             |                               |
|             | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer   | edicai              | (Check only 2 Medical Ex  | Physician: To the best of caminer: On the basis of |                 |                      |                             |                                 |                         |  |                   |                   |                         |                             | e(s)                          |
|             | the hin 2, the limber the limblet  | Med                 | one)  | and manner sta                                     | led.            |                      | 290                         | l icense n                      | umber                   |  |                   | Jod Date          | signed /Mor             | th Day Yes                  | rl                            |
| )           | L M O  |                     | 29b. Signature and title of certifier   | Man  |                 |                      | m                           | 2011/                           | 201 5                   | 1/17                                   | מומ               | July Date         | DAIC 2                  | 1., 20y, rea.               | 06                            |
| ,           | 20   |                     | 30. Name and address of person w  | no completed cause of d                            | eath /Item 22   | la) (Tuno            | Print)                      | 1410                            | ura D                   | 77                                     | UIX               | <u> </u>          | UIVE 3                  | C                           | 125.111                       |
|             |  |                     | 0 , 1 1   | OSENBERG   | Juli (110111 23 | ( ypa,               | DPP91                       | R                               | 1065                    | 7                                      | 110 1             | OBR               | ECHTA                   | n M.                        | 1 217                         |
|             | Sta  | te                  | 31. Date filed (Month, Day, Year)   | 32 Registra  | ar's Signature  | • /                  | 10                          |                                 |                         |  |                   |                   |                         | 1.16                        | 1)<br>06<br>(esville<br>d 217 |
|             | Registr  | ar                  | JUL 06  | 2006 June  | J. J.S.         | ROOM                 | W.                          |                                 |                         |  |                   |                   |                         |                             |                               |

DHMH 17 Rev 1/2001

|                            |   | 1                    | For<br>State<br>Registrar   | State of Maryl   |                                     | artment of H<br>rtificate of L  |                                | Re                                    | Reg. No.   |  |                                 |  |
|----------------------------|---|----------------------|---|--|-------------------------------------|---|--------------------------------|---------------------------------------|--|--|---------------------------------|--|
|                            | Physicia  | an                   | Decedent's Name (First, Middle, Last)     MARY ELIZABETH RO   | NZO  |                                     |   |                                | 2. Date of Death Month July 8,        | Day  | Year   | ime of Death                    |  |
| <b>)</b> =                 | /Medic<br>Examin  | 444                  | 4a. Facility Name (If not institution, give str<br>Somerford Place  | eet and number)  |                                     | 4b. City, Town, or<br>Hagersto  |                                | 1                                     | 4c. County of  | of Death<br>ngton Co                                       | ounty                           |  |
|                            | Funeral<br>Director   |                      | 5. Social Security Number 6. Sex  | 7. Age (In   | yrs. last birthday)<br>Yrs.         | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, May 13, | Year)  | 9. Birthplace (S<br>Country)<br>New Jers                   |                                 |  |
|                            | within 72 hours after death with the Maryland tibe. tibe. The Madical Examiner cust be motified at  | i Director           | Usual Residence of Decedent  10a. State  10b. County  Maryland Washington  10e. Street and Number  10114 Sharpsburg F   | County H   | . City, Town or Lo<br>agerstow      |   |                                |                                       | 0g. Citizen of W   | 10   | ide City Limits                 |  |
| 1215-0036                  | hours after deatl<br>tural', or iteme 2<br>al Exeminer nu   | ed by Funeral        | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | . Was Decedent Ever<br>Armed Forces?<br>1 ☐ Yes 2 No<br>If Yes, Give<br>Year or Dates:             |                                     | Was Decedent of Hi<br>If Yes, specify Cuba<br>1 Yes 2 No<br>dent's Usual Occupa | Specify:                       | o Rican, etc.)                        |  | White  | an,                             |  |
| -61212                     | d within 72<br>giene.<br>r then "nat  | Completed            | (Specify only highest grade   |  | (Give                               | kind of work done of<br>DO NOT use retired                                      | during most of wor             | rking                                 |  | l Reside   | ence                            |  |
| Maryland 2                 | should be filed w<br>nd Mental Hygier<br>s marked other th<br>umatic event. In  | To Be C              | 17. Father's Name (First, Middle, Last)  Joseph Scerra  |  |                                     |   | Teresa                         | me (First, Middle, M                  |  |  |                                 |  |
| Mary                       | d 2 sho<br>th and h<br>t7 is ma<br>traums   |                      | 19a. Informant's Name/Relationship (Type<br>Eileen R. Shatzer /   |  |                                     | ng Address <i>(Street a</i><br><b>Cadillac</b>                                  |                                |                                       |  |  |                                 |  |
| Baltimore,                 | permit. Pages 1 and 2 should by<br>Department of Health and Menta<br>Important: if Item 27 is marked<br>eny injury or other traumatic en  |                      | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)  | moval from State   | Db. Place of Dispo<br>cemetery, cre |   | Θ)                             |                                       | 20c. Location - 0  | City or Town, St   | ate                             |  |
| Balt                       | permit. P<br>Departm<br>Importar<br>eny injur   |                      | 21. She ature of Funeral Service Licensee   |  | 2:                                  | 2. Name and Address   | ss of Facility Do              | ouglas A.                             | Fiery :  | Funeral  | Home                            |  |
| 8760,                      | Physician // Medical Examiner und its pruratitansit   | dical Examiner       | 23a. Part1. Enter Me disease, of complicishook, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d. | cause on each line.  | e i pre in a sequence of):          | 0   | g, such as cardiac             |                                       | est.   | Interv   | oximate val Between t and Death |  |
| O. Box 68                  | the death certifica<br>y the attending ph<br>ched for use as th   | Physician/Med        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | c. If yes, outcome of pr<br>1 Live birth 2<br>4 Pregnant at time<br>9 Unknown                      | Fetal death 3                       | □Ectopic pregnancy  |                                |                                       | 23d. Date<br>Mon   | e of delivery<br>hth Day                                   | Year                            |  |
| ۵.                         | w requires that the de<br>been signed by the<br>should be detached  | <u>م</u> ا           | Part II. Other significant conditions cont  | ributing to death but no   | t resulting in the u                | Inderlying cause give   | en in Part I.                  | 23e. Did tot                          |  | ibute to the caus  | se of death?                    |  |
| Reco                       | The law re<br>ate has bee<br>page 2 sho   | Completed            |   |  | σ                                   |   |                                | 24a. Was a autops perform             | y p<br>ned? d  | Vere autopsy fin<br>rior to completic<br>leath?<br>Yes 2 N | on of cause of                  |  |
| Division of Vital Records, | To the Hoapital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Certification: To Be | 25. Was case referred to medical examiner?  1   | spital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yei 28e. Place of Injury - building, etc. (S | At home, farm, st                   | of 28c. Injun<br>Wor<br>M 1   | er: 4 Nursing H                | 28d. Describe ho                      | escribe how injury occurred  Cation (Street and Number or Rural Route Number, by or Town, State) |  |                                 |  |
|                            | To the Hoapital within 24 hours a To the Funeral Completely filled  | edicai Ce            |   | cian: To the best of my<br>er: On the basis of exa<br>and manner stated.                           |                                     |   |                                |                                       |  |  | ause(s)                         |  |
| •                          | To the within 2 To the complete   | Me                   | 29b. Signature and title of certifier  Many E Ma  | w,6)   |                                     | 29c. Licens   | 387 5                          | 2                                     | 9d. Date signed  | (Month, Day, Y   | 'ear)                           |  |
| 31                         | 4-20<br>St  |                      | 30. Name and addres of person who core Mour Month. (Month, Qay, Year)   | nplet cause of death  32. Registrar's  | 354                                 | Print)  | + 1-lage                       | rstowr                                | n Md   | 21740  |                                 |  |
|                            | Regist  | rar                  | JUL 12 20   | 06 France  | . A. B                              | carle   |                                |                                       |  |  |                                 |  |

ORIGINAL

|                     |   | 1                  | For<br>State<br>Registrar   | State of Maryla  |                     | artment of H<br>tificate of L              |                                |                                | giene<br>Reg. No.                | <b>36</b>                      | 22814  |
|---------------------|---|--------------------|---|--|---------------------|--|--------------------------------|--------------------------------|----------------------------------|--------------------------------|--|
|                     | *   |                    | Decedent's Name (First, Middle, La  | ist)   |                     |  |                                | 2. Date of Dea                 |                                  | Year                           | 3. Time of Death                                   |
|                     | Physicia  |                    | Audell  | Ε.   |                     | Sa   | voy                            |                                | 3,2006                           |                                | 6:30A M  |
|                     | /Medic<br>Examin  |                    | ta. Facility Name (If not institution, gir                                    | ve street and number)                                  |                     | 4b. City, Town, or                         | Location of Death              | )                              | 4c. County of                    | of Death                       |  |
| н                   | LXaiiiiii   | •                  | Genesis Elder   | Care   |                     | LaPla                                      |                                |                                | Char                             | les_                           |  |
|                     | Funeral   |                    | 5. Social Security Number 6.  | Sex 7. Age (In y                                       | rs. last birthday)  | If Under 1 Year<br>Months Days             | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birt<br>(Month, Da) | , Year)                          | 9. Birthpla<br>Country<br>Mary | ce (State or Foreign                               |
|                     | Director  |                    | 217-26-8138   | <sup>1□ M 2</sup> 76                                   | Yrs.                |  |                                | 10-07-                         | 1929                             | nary.                          | Land   |
|                     | D .   | <u> </u>           | Usual Residence of Decedent  10a. State 10b. County                           | 100.   | City, Town or Lo    | cation                                     |                                |                                |                                  | 100                            | d. Inside City Limits                              |
|                     | anyla<br>shov   | _                  |   |  | Clintor             |  |                                |                                |                                  |                                | X□Yes 2□No   |
|                     | he M  | ect                | Maryland Prince   | e George (   | CITITOI             | 10f, Zip Code                              |                                |                                | 10g. Citizen of W                | hat Countr                     | y?   |
|                     | with t  | ä                  |   | ner Dood   |                     | 2073                                       | 15                             |                                | USA                              |                                |  |
|                     | eath  | eral               | 9709 Piscatawa  | 12. Was Decedent Ever i                                | n U.S. 13.          | Was Decedent of H                          |                                | pecify Yes or No               |                                  | - America                      |  |
| 36                  | s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. It is Medical Examinating to mailified at | by Funeral Directo | 1 Never Married 2X Married 3 Widowed 4 Divorced                               | Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates: |                     | If Yes, specify Cuba<br>1 ☐ Yes 2 🔀 No     | Specify:                       | o Hican, etc.)                 |                                  | k, White, et                   |  |
| Maryland 21215-0036 | tura<br>cal E   | ed                 | 15. Decedent's l  | Education  | 16a. Dece           | dent's Usual Occup                         | ation                          | rking                          | 16b. Kind of Bu                  | siness/Indu                    | ıstry  |
| 7                   | n n n   | ple                | (Specify only highest g   | College (1-4or 5+)                                     | life.               | kind of work done of<br>DO NOT use retired | 1)                             | 9                              |                                  |                                |  |
| 212                 | d with<br>giene.  | Completed          | 12  | ,  | Sı                  | perviso                                    |                                |                                | Montgo                           |                                | Ward   |
| פ                   | at Hygie<br>other<br>vent.  | Be C               | 17. Father's Name (First, Middle, Las   | st)  |                     |  |                                |                                | Maiden Sumam                     |                                | . 1  |
| <u>a</u>            | 2 should be to and Mental I is marked o raumatic eve  | 10                 | Charles   |  | Ford                |  | Elizabe                        |                                |                                  | Smi                            |  |
| ar                  | sho<br>s me   |                    | 19a. Informant's Name/Relationship  | _  |                     | ng Address (Street                         |                                |                                |                                  |                                |  |
| Ž                   | 1 and 2<br>Health<br>Jem 27 is  |                    | Walter Savoy  | / Husband  |                     | Piscata                                    |                                | , Clint                        | 20c. Location -                  |                                |  |
| ore                 | of He fiten   |                    | 20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3                         | Removal from State                                     | -                   | osition (Name of<br>matory or other plac   |                                |                                |                                  | -                              |  |
| Ĕ                   | Pag<br>nent<br>ant: I   |                    | `4 □Donation 5 □ Other (Spec  | cify) R  | esurre              | ction Ce                                   | em.  7/1                       |                                |                                  |                                | aryland  |
| Baltimore,          | permit. Pages 1 an<br>Department of Heal<br>Important: If item 2<br>any injury or other<br>once.  |                    | 21. Signature of Funeral Service Lic  | 111 11 (11)  | 191 A               | 2. Name and Addre                          | eral He                        | 605 Aqu<br>ome PA              | asco,<br>Aquasc                  | Mary<br>o,MD                   | land<br>20608                                      |
|                     |   |                    | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on      | mplications that caused the                            | death. Do not en    | ter the mode of dyir                       | ng, such as cardia             | c or respiratory a             | rrest,                           |                                | Approximate<br>Interval Between<br>Onset and Death |
| 8                   | Physician   |                    | Immediate Cause (Final disease or condition                                   | Multi  | He                  | Sclero                                     | dis                            |                                |                                  |                                | Onset and Death                                    |
|                     | /Medical  |                    | resulting in death)   | Due to (or as a cor                                    | nsequence of):      |  |                                |                                |                                  |                                |  |
| 10                  | Examiner  |                    | Sequentially list conditions,   | b  |                     |  |                                |                                |                                  |                                |  |
|                     | n =   | ner                | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a cor                                    | nsequence of):      |  |                                |                                |                                  |                                |  |
|                     | cuted   | Examin             | that initiated events   | c  |                     |  |                                |                                |                                  |                                |  |
| Ö,                  | i be executed<br>sician and<br>burial-transit   | Ě                  | resulting in death) Last  | Due to (or as a con                                    | iisequerice oi).    |  |                                |                                |                                  |                                |  |
| 8760,               | ate b<br>hysic<br>the bi  | lca                | •   | d  |                     |  |                                |                                |                                  |                                |  |
| 9                   | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit  | Physiclan/Medical  | IF FEMALE:  | 23c. If yes, outcome of pr                             | 70.000.000          |  |                                |                                | 23d Dat                          | te of deliver                  | D/   |
| Вох                 | ath ce  | lan/               | 23b. Was decedent pregnant in the past 12 months?                             | 1 Live birth 2 □ 4 □ Pregnant at time                  | Fetal death 3       | □Ectopic pregnanc<br>□ Other (specify) _   | у                              |                                | Ma                               |                                | Day Year   |
|                     | the a   | /sic               | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9☐ Unknown   | or death 5          |  |                                |                                |                                  |                                |  |
| P.0                 | res that the designed by the a  | Ph                 | Part II. Other significant condition  | s contributing to death but no                         | ot resulting in the | underlying cause gr                        | ven in Part I.                 | 23e. Did                       | tobacco use cont                 | ribute to the                  | e cause of death?                                  |
| S,                  | signe<br>signe  | by                 | Takin salar sajan   |  |                     |  |                                | 1 🗆                            | Yes 2 No                         | 3 🗌 Proba                      | ably 4 Unknown                                     |
| Records,            | w require<br>been si<br>should b  | Completed          |   |  |                     |  |                                | 24a. Was                       | an 24b.                          | Were autor                     | osy findings available                             |
| lec                 | e 2 s   | npl                |   |  |                     |  |                                | auto<br>perf                   | opsy<br>ormed?                   | prior to con<br>death?         | npletion of cause of                               |
| =                   | : The   | S                  |   |  |                     |  |                                | 1 ☐ Yes                        |                                  | 1 🗌 Yes                        | 2 L No   |
| Vital               | ding Physician: The law<br>n.<br>Atter this certificate has b<br>funeral director, page 2 s   | Be                 | 25. Was case referred to medical examiner?                                    | Hospital:  |                     | -Cast Ot                                   | hor                            | ath Check onl                  |                                  | or (Canait                     | 4)   |
| of                  | £ 15 0  | 2                  | 1 ☐ Yes 2 ☑ No 27. Manner of Death  | 1 ☐ Inpatient  | 2 ER/Outpation      | ent 3 DOA                                  | 4 Milliamy                     | -                              | idence 6 Oth<br>how injury occur |                                | 7  |
| 'n                  | ing F<br>After<br>uner  | lon                | 1 Natural 5 ☐ Pending   | (Month, Day Ye   | ar) Injury          | Wo   | ork?<br>]Yes 2∐No              |                                |                                  |                                |  |
| Sic                 | Health<br>Hor:<br>The   | Cat                | 3 Suicide 6 Could no  | ot be 290 Place of Injury                              | At home, farm, s    | street, factory, office                    | AT EAST                        |                                | (Street and Numb                 | oer or Rura.                   | l Route Number,                                    |
| Division            | or Atter<br>Direction by  | Certification; To  | 4 Homicide determin   | building, etc. (S                                      | Specify)            |  |                                | City or 10                     | iwn, State)                      |                                |  |
|                     | pital<br>ours<br>eral<br>filled   | S S                | 29a. Certifier 1 X Certifying   | Physician: To the best of m                            | iy knowledge, de    | ath occurred at the t                      | ime, date and plac             | ce, and due to the             | cause(s) and ma                  | anner as st                    | ated.  |
|                     | To the Hospital or Attending P. within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral   | edical             | (Check only 2 Medical E   | xaminer: On the basis of exa<br>and manner stated      | amination and/or    | investigation, in my                       | opinion, death occ             | curred at the time             |                                  |                                |  |
|                     | ro th<br>vithin<br>ro th  | Me                 | 29b. Signature and title of certifier   | NO Hom   | 1112                | 29c. Licen                                 | ise number                     | 136                            | 29d. Date signe                  |                                | 7.   |
|                     | ->-0  | İ                  | · Nahi  | Mathin   | 140                 |  | )522                           | 87                             | •                                | 7/3                            | 5 /06  |
| (                   |   |                    | 30. Name and address of person w  | no completed cause of death                            | h (Item 23a) (Typ   | e, Print)                                  |                                | ·                              |                                  |                                |  |
| 1                   | BO  |                    | D- 37 3 1 36 13   | 10 St  | Patric              | ks Dr.                                     | Waldorf                        | , Mary                         | land 20                          | 601                            |  |
| 1                   | S   | ate                | 31. Date filed (Month, Day, Year)   | 6 2006 32. E gistrar's                                 | Signature           | had a                                      |                                | _                              |                                  |                                |  |
|                     | Regis   | trar               | JUL V   | 0 2000   | 100                 |  |                                |                                |                                  |                                |  |

|                                |   |                  | 1 - Stata<br>Registrar AMEND#8perFH7   |  |                                |                        | artment of H                                   |                            | ind Me                    |                                    | giene<br>Reg. No   | 400                               | 6 22                               | 281                  |  |  |
|--------------------------------|---|------------------|--|--|--------------------------------|------------------------|--|----------------------------|---------------------------|------------------------------------|--|-----------------------------------|------------------------------------|----------------------|--|--|
|                                |   |                  | Decedent's Name (First, Middle, Last   |  |                                |                        |  |                            | 2                         | 2. Date of Dea                     | ath  |                                   | 3. Time of                         | f Death              |  |  |
|                                | Physicia  |                  | Gladys Virgi   | inia Cim   | mons                           |                        |  |                            |                           | Month<br>June 29                   | Day<br>O 2   | y Year<br>.006                    | 3:00                               | A M                  |  |  |
| J                              | /Medic<br>Examin  |                  | 4a. Facility Name (If not institution, give  |  | mons                           |                        | 4b. City, Town, or                             | Location of                |                           | June 2.                            | -  | County of Dea                     |                                    |                      |  |  |
|                                | LAdillii  | CI               | 3530 Woodbine ST   |  |                                |                        | Chevy Ch                                       | 200                        |                           |                                    | м  | ontgome                           | 2017                               |                      |  |  |
|                                | Funeral   |                  | 5. Social Security Number 6. Se  | x 7. Age   | e (In yrs. last b              | irthday)               | If Under 1 Year                                | If Under 2                 | 24 Hrs. g                 | 3. Date of Birt                    | h5,-5  | -1913. Bir                        | thplace (State o                   | or Foreign           |  |  |
|                                | Director  |                  | 577-03-7825  | ☐M 2[] F   | 93                             | Yrs.                   | Months Days                                    | Hours                      | Min.                      | Month, Da                          | of Birth5-5-1913. Birthplace (State or Foreign th, Day, Year) Virginia |                                   |                                    |                      |  |  |
| -                              | מ   |                  | Usual Residence of Decedent  |  |                                |                        |  |                            |                           |                                    |  | 720                               |                                    |                      |  |  |
|                                | ylan  |                  | 10a. State 10b. County   |  | 10c. City, To                  | wn or Lo               | cation   |                            |                           |                                    |  |                                   | 10d. Inside C                      | ity Limits           |  |  |
|                                | Mar   | ţo               | Maryland Montgome  | ery  | Chevy                          | Cha                    | se   |                            |                           |                                    |  |                                   | 1 Tyes                             | 2 X No               |  |  |
|                                | r 284   | rec              | 10e. Street and Number   |  |                                |                        | 10f. Zip Code                                  |                            |                           |                                    | 10g. Cit   | izen of What Co                   | ountry?                            |                      |  |  |
|                                | h wit   | <u>α</u>         | 3530 Woodbine Stre   | eet  |                                |                        | 20815  |                            |                           |                                    | U.S.   | Α.                                |                                    |                      |  |  |
|                                | deet  | Funeral Director | 11. Marital Status   | 12. Was Decedent I<br>Armed Forces?                                | Ever in U.S.                   | 13.                    | Was Decedent of Hi<br>f Yes, specify Cuba      | spanic Orig                | in? (Speci                |                                    |  | 14. Race - Ame                    |                                    |                      |  |  |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any highry of other traumatic avant, the Medical Exertical must be notilled at anone. | by Fu            | 1 ☐ Never Married 2 ☐ Married<br>3 🛣 Widowed 4 ☐ Divorced  | 1 Yes 2 X  | 40                             |                        | 1 ☐ Yes 2X No                                  | Specify:                   | , ruello ni               | ican, etc.)                        |  | Black, White Specify: Wh          |                                    |                      |  |  |
| ŏ                              | tura<br>ear   | Completed by     | 15. Decedent's Edu   | ucation  | 16                             | a. Dece                | dent's Usual Occupa                            | ition                      |                           |                                    | 16b. K   | ind of Business                   |                                    |                      |  |  |
| 5                              | in 72   | piet             | (Specify only highest grad   | de completed)  |                                | (Give                  | kind of work done of<br>DO NOT use retired     | lurina most                | of working                | 7                                  |  |                                   | ,                                  |                      |  |  |
| 7                              | the the   | Ē                | Elementary/Secondary (0-12)  | College (1-4or 5   | )+)                            | Ноп                    | emaker   |                            |                           |                                    | Otar   | Home                              |                                    |                      |  |  |
| פ                              | filed<br>Hyg<br>othe  | Be C             | 17. Father's Name (First, Middle, Last)  |  |                                | 1101                   | Cincia   | 18. Mother                 | r's Name (                | First, Middle,                     |  |                                   |                                    |                      |  |  |
| a                              | id be<br>ental<br>kad<br>ic av  | To B             | Robert Lucas   |  |                                |                        |  | Anni                       | ie Jai                    | ne Beli                            | 1  |                                   |                                    |                      |  |  |
| ₩<br>Z                         | shou<br>mar<br>mat  | -                | 19a. Informant's Name/Relationship (T)   | ype, Print)  | 19                             | b. Mailir              | ng Address (Street a                           | ind Numbe                  | r or Rural I              | Route Numbe                        | er, City o   | or Town, State, .                 | Zip Code)                          |                      |  |  |
| ž                              | th a  |                  | John Ross / Friend   | ł  | 1                              | 3516                   | Haddonfi                                       | eld I                      | n. D:                     | arnest                             | Own  | MD 208                            | 878                                |                      |  |  |
| ē,                             | Hea Hea   |                  | 20a. Method of Disposition   | <del>-</del>   | 20b. Place                     | of Dispo               | sition (Name of                                |                            | Da                        |                                    |  | ocation - City or                 |                                    |                      |  |  |
| <u>o</u>                       | ages<br>not of<br>t: if i   |                  | W☐ Burial 2 ☐ Cremation 3 ☐ F  |  |                                |                        | natory or other place                          | ل ا                        | July (                    |                                    | D  |                                   | 77.2 d                             |                      |  |  |
| 튤                              | it. P   |                  | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens  |  | Gree                           |                        | .11 Cemete<br>2. Name and Addres               |                            | 200                       |                                    |  | yville,                           |                                    | ııa                  |  |  |
| Ba                             | Depart Impo   |                  | Jefu (n)   | 2-   |                                |                        | 130 Wisco                                      |                            | Jose                      |                                    |  | 's Sons                           |                                    |                      |  |  |
|                                |   |                  | 23a. Part1. Enter the disease, or comp   | lications that caused  | the death, Do                  |                        |  |                            |                           |                                    |  | D.C. 20                           | Approximat                         | te                   |  |  |
|                                |   |                  | shock, or heart failure. List only o<br>Immediate Cause (Final   |  |                                |                        |  |                            |                           |                                    |  |                                   | Onset and                          | Death                |  |  |
|                                | Pnysician<br>/Medical   | 1                | disease or condition resulting in death)   | u  |                                |                        | Failure  |                            |                           |                                    |  |                                   | 3 Days                             | 3                    |  |  |
|                                | Examiner  |                  |  |  | a consequenc                   | ,                      |  |                            |                           |                                    |  |                                   |                                    |                      |  |  |
|                                |   | _                | Squentially list conditions if any, leading to immediate b. Myocardial Infartion  Due to (or as a consequence of): |  |                                |                        |  |                            |                           |                                    |  |                                   | 3 Mont                             | hs                   |  |  |
|                                | led<br>rsit   | ole              | cause. Enter Underlying Cause (Disease or injury   | •  |                                |                        |  |                            |                           | 20. 17                             |  |                                   |                                    |                      |  |  |
|                                | and<br>and<br>II-trai   | Examiner         | that initiated events resulting in death) Last   | c. Aortic  Due to (or as   | a consequence                  |                        | ase  |                            |                           |                                    |  |                                   | 20 Year                            | :s                   |  |  |
| 8760,                          | cate be executed<br>physicien and<br>the burial-transit   | E E              |  | •  | ,                              | •                      | use Ather                                      | necle                      | rnei                      | c                                  |  |                                   | 20 Year                            | 66                   |  |  |
| 387                            |   | dicai            |  | d. GOT GHAT  | y and                          | <b>71</b> 11           | ase mener                                      | OSCIE                      | LUBI                      | 3                                  | _  |                                   | ZU TEAL                            | . 5                  |  |  |
| 9 X                            | death certific<br>e attending p<br>ed for use as  | Physician/Me     | IF FEMALE:   | 23c. If yes, outcome   | of pregnancy                   |                        |  |                            |                           |                                    |  | 00d Date of de                    | ľ                                  |                      |  |  |
| Вох                            | atten<br>for u  | ian              | in the past 12 months?   | 1 ☐ Live birth<br>4 ☐ Pregnant at                                  | 2 Fetal dea                    |                        | Ectopic pregnancy Other (specify)              |                            |                           |                                    |  | 23d. Date of de<br>Month          |                                    | Year                 |  |  |
| o.                             | 0 0 0   | ysic             | 1 ☐ Yes 2 🖾 No<br>9 ☐ Unknown  | 9☐ Unknown   | ume or death                   | 3                      | JOther (specify)                               |                            |                           |                                    |  |                                   |                                    |                      |  |  |
| م.                             | that the de<br>ed by the<br>detached  | P                | Part II. Other significant conditions co   | antributing to death b   | ut not resulting               | in the u               | nderwing cause give                            | n in Part I                |                           | 23e. Did to                        | obacco i   | use contribute to                 | the cause of d                     | death?               |  |  |
| Vital Records,                 | es<br>pe pe   | by               | • • • • • • • • • • • • • • • • • • •  | , <b>.</b>   |                                |                        | ndonyg occobe give                             |                            |                           |                                    |  | XINo 3□Pi                         |                                    |                      |  |  |
| 5                              | w requir  | Completed        | <del></del>  |  |                                |                        |  |                            |                           |                                    |  |                                   |                                    |                      |  |  |
| ec                             | hes by  | n d              |  |  |                                |                        |  |                            |                           | 24a. Was<br>autop                  | SY   | 24b. Were at                      | utopsy findings<br>completion of c | available<br>ause of |  |  |
| <u> </u>                       | 10 L  | ò                |  |  |                                |                        |  |                            |                           |                                    | rmed?<br>2√∏ No  | death?                            | 2 ₹ No                             |                      |  |  |
| /ita                           | ysician: Th<br>is certificate<br>director, pag  | Be               | 25. Was case referred to medical examiner?   |  |                                |                        |  |                            | of Death (                | Check only o                       | ne)  |                                   |                                    |                      |  |  |
| 5                              | Q 50  | ္                | 1 ☐ Yes 2X No  | Hospital:<br>1 ☐ Inpatie   | nt 2 ER/C                      | Outpatier              |  | 4   1401                   | sing Home                 | e 5 X Resid                        | dence  | 6 □Other (Spe                     | city)                              |                      |  |  |
| _                              | fler t  | Ë                | 27. Manner of Death 1 Natural 5 ☐ Pending  | 28a. Date of Injui<br>(Month, Day                                  | ry 28b<br>y Year)              | . Time of<br>Injury    | 28c, Injury<br>Work                            | at                         | 28                        | d. Describe h                      | now injur  | y occurred                        |                                    |                      |  |  |
| <u>.</u>                       | Attanding r death. actor: Alter   | ati              | 2 Accident investigation   |  |                                |                        |  | res 2□N                    | 10                        |                                    |  |                                   |                                    |                      |  |  |
| Division                       | or Att  | Certification;   | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of Inju-<br>building, etc                               | ury - At home,<br>c. (Specify) | farm, str              | eet, factory, office                           |                            | 28                        | f. Location (S<br>City or Tow      | Street an<br>vn, State   | d Number or Ri                    | ural Route Num                     | ber,                 |  |  |
|                                | ital c<br>irs af<br>rat Di<br>led ir  |                  |  |  |                                |                        |  |                            |                           |                                    |  |                                   |                                    |                      |  |  |
|                                | To the Hospital or Attending Phwithin 24 hours atter death. To the Funeral Director: After the cumpletely filled in by the funeral  | Medical          | 29a. Certifier 1 A Certifying Phy (Check only 2 Madical Examone)   | ysician: To the best of<br>iner: On the basis of<br>and manner sta | examination a                  | ge, deatl<br>and/or in | n occurred at the tim<br>vestigation, in my op | e, date and<br>inion, deat | d place, an<br>h occurred | d due to the d<br>d at the time, d | cause(s)<br>date and   | and manner as<br>d place, and due | s stated.<br>to the cause(s        | <b>;</b> )           |  |  |
|                                | To the To the Cumplet   | Me               | 29b. Signature and title of certifier  | 1 10   | N 1                            | *                      | 29c. License                                   | number                     |                           | :                                  | 29d. Da  | te signed (Mont                   | h, Day, Year)                      |                      |  |  |
|                                |   |                  | * Kie  | parol 01   | Lule                           | un                     | D-2115   | /1                         |                           |                                    |  | 6/29                              | 106                                |                      |  |  |
|                                | 10  |                  | 20 Name and address of access the a  | completed cause of d   | 200                            | ) (Tue-                | 1  |                            |                           | 16 -                               |  | 7/2/                              | 100                                |                      |  |  |
|                                |   |                  | 30. Name and address of person who c   |  |                                | -                      | RICHA  |                            |                           | M.D.                               |  |                                   |                                    |                      |  |  |
|                                | Sta   | te               | 5530 Wisconsin Av  | 7e. Suite<br>32. Registra  | 750 C                          | nevy                   | _Uhase,_M                                      | D_208                      | 15                        | -                                  |  |                                   |                                    |                      |  |  |
|                                | Registr   |                  | JUL 062  | anne A   | ar's Signature                 | 6                      | market 9                                       |                            |                           |                                    |  |                                   |                                    |                      |  |  |

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| Please Type or Print in Black Indelible Ink. | Ensure All Copies Are Legible |
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|--|-------------------------------|

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2006 **Physician** July 3, Harry SHULMAN 5:15 A. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 18, 1908 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5 Social Security Number 6. Sex **Funeral** Months **X**□M 2□F Latvia 053-01-6153 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Rockville Montgomery 10g. Citizen of What Country? 10e, Street and Number 10f. Zin Code 6121 Montrose Rd., #581 20852 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, the Medical Examinal must injury or other traumatic event, the Medical Examinal must proce. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ➡Widowed 4 ☐ Divorced þ White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Dept. of Labor Statistician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) David Shulman Reva Reuben 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Aviva Harvey / daughter 4345 Star Ranch Rd., Colorado Springs, CO 80906 20a. Method of Disposition
143 Burial 2 Cremation 3 Removal from State
14 Donation 5 Officer (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Judean Memorial Garden July 4, 2006 Olney, MD 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Frine all envis Lives 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ADENOCARCINOMA Immediate Cause (Final . Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner dany leading to immedicause. Enter Underlying Cause (Disease or injury burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Physician/Medical use as the IE EEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, SCHEMIC 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🎇 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Surrsing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Magner of Death After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after deat To the Funeral Director; 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier L CO 36 Name and address of person who completed cause of death (Kem 23a) (Type, Print) TRO & 021 MOR NESH MD 31. Date filed (Month, Da Day. State 06 Registrar

|   |                   | 1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death  Reg. No.  |  |  |                        |                  |   |                         |  |                                   |                                      |  |   |  |
|---|-------------------|--|--|--|------------------------|------------------|---|-------------------------|--|-----------------------------------|--------------------------------------|--|---|--|
| Ξ   |                   | 1. Decedent's Name (First, Middle, Las   | ')   |  |                        | V                |   |                         |  | 2. Date of Dea                    | ath<br>Day                           | Year   | 3. Time of Dea  |  |
| Physici<br>/Medio   |                   | Joan M. G. Se  | chler  |  |                        |                  |   |                         |  |                                   |                                      | 006  | 6:55 a  |  |
| Examir  |                   | 4a. Facility Name (If not institution, give  | street and numb  | er)  |                        | 4b. City, To     | wn, or L  | ocation of              | Death                                  |                                   | 4c. C                                | ounty of Deat  | h   |  |
|   |                   | Holy Cross Hospi   | tal  |  |                        | Sil              | ver   | Spri                    | ng                                     |                                   |                                      | Mont   | gomery  |  |
| Funeral   |                   | 5. Social Security Number 6. Se  |  | Age (In yrs.   | last birthday)         | If Under 1 Y     | ear<br>ays  | If Under 2              | 4 Hrs.<br>Min.                         | 8. Date of Birt<br>(Month, Da     | h<br>Vearl                           | 9. Birti   | hplace (State or For  |  |
| Director  |                   | 578-13-1254  | ∃M 2 <b>⊠</b> F  | 58   | Yrs.                   | Wichtis          | ays   | riours                  |  | Nov. 22                           |                                      |  | **  |  |
|   |                   | Usual Residence of Decedent  |  |  |                        |                  |   |                         |  |                                   |                                      |  |   |  |
| naturel', or iteme 23a or 28a-f ehow<br>dical Examinar must be indiffied at   | L                 | 10a. State 10b. County   |  | 10c. Cit   | ty, Town or Lo         | cation           |   |                         |  |                                   |                                      |  | 10d. Inside City Li   |  |
| i   | cto               | Maryland Montgome  | ery  | Si   | lver S                 | pring            |   |                         |  |                                   |                                      |  | 1 ☐ Yes 2 🔯   |  |
| 28  | Director          | 10e. Street and Number   |  |  |                        | 10f. Zip Co      | ede   |                         |  |                                   | 10g. Citize                          | n of What Co   | untry?  |  |
| 23a   | aic               | 9312 Glenville H   | Road   |  |                        | 20               | 901   |                         |  |                                   |                                      | USA  |   |  |
| 2 3   | Funerai           | 11. Marital Status   | 12. Was Decede   |  |                        | Was Deceden      | panic Origi   | in? (Spe                | cify Yes or No                         | - 14                              | Race - Ame                           |  |   |  |
| 18  | 2                 | 1 Never Married 2 TMarried   | 1 ☐ Yes 2  |  |                        | f Yes, specify   |   |                         | rueito                                 | nicari, etc.)                     |                                      | Black, White   |   |  |
| - 3   | þ                 | 3 ☐ Widowed 4 ☐ Divorced   | If Yes, Give<br>Year or Date                           | es:  | :                      | 1□Yes 2□         | ΧNO   | Specify:                |  |                                   | S                                    | pecify:Whi   | te  |  |
| ical in   | ted               | 15. Decedent's Ed<br>(Specify only highest grad  | cation   |  |                        | tent's Usual C   |   |                         | of worki                               | 7.0                               | 16b. Kind                            | of Business/   | Industry  |  |
| 2 3   | g                 | Elementary/Secondary (0-12)  | College (1-4   | or 5+)   | life.                  | DO NOT use r     | etired)   | ing most c              | JI WOIKI                               | 19                                |                                      |  |   |  |
| h and Mental Hygiene.<br>7 le marked other than "<br>reumatic event, 1.e Mer  | Completed         | ,  | 4  |  | Bio                    | logist           |   |                         |  |                                   | Nat                                  |  | Institute<br>alth   |  |
| oth<br>ent,   | Be C              | 17. Father's Name (First, Middle, Last)  |  |  |                        |                  | 1   | 8. Mother               | 's Name (First, Middle, Maiden Sumame) |                                   |                                      |  |   |  |
| ked<br>ked  | To B              | David Greenfield   | 1  |  |                        |                  |   | Cha                     | rlot                                   | te Busl                           | bv                                   |  |   |  |
| nd N<br>mat   | -                 | 19a. Informant's Name/Relationship (T  |  |  | 19b. Mailir            | ng Address (S    | treet an  |                         | -                                      |                                   | umber, City or Town, State, Zip Code |  |   |  |
| Ith a   |                   | D. Stanton Sechle  | r/ Husb  | and  | 9312                   | Glenv            | i 11e   | - Road                  | d. 9                                   | Silver                            | Sprin                                | a. MD  | 20901   |  |
| Hee   |                   | D. Stanton Sechler/ Husband  20a. Method of Disposition  1 Burial 2 Deficemation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify)  20c. Location - City or July 5,  Metropolitan Crematory |  |  |                        |                  |   |                         |  |                                   |                                      |  |   |  |
| nent of h<br>ant: If Ita<br>ary or o  |                   |  |  |  |                        |                  |   | ' ∤ Ј                   |  |                                   |                                      |  |   |  |
| tant<br>njury   |                   | 4 □ Donation 5 □ Other (Specify  |  | Met  |                        |                  | ame and Address of Facility ICIS J. Collins Funeral Home Inc. |                         |  |                                   |                                      |  | Virginia  |  |
| Department of Heelth and Mental Hygiene. Important: If Item 27 Ie marked other than "naturel", or Iteme 23e or 28a-f ehow eny injury or other treumatic event, the Medical Exeminar must be invitted at ODEs. |                   | 21. Signature of Funeral Service Licen:  | J Cole   |  |                        |                  |   |                         |  |                                   |                                      |  | g, MD 209   |  |
| Medical xaminer purial-transit  | i Examiner        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b<br>Due to (or  | as a consequence as a c | uence of):             |                  |   |                         |  |                                   |                                      |  |   |  |
| ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown  Part II. Other significant conditions co   | 4□Pregnan<br>9□Unknow                                  | n 2 ☐ Feta<br>It at time of d<br>n   | Il death 3             | Ectopic pregr    | ý)  | in Part I               |  | 23a Did tr                        |                                      | d. Date of deliment                                      | very Day Year   |  |
| been signe<br>should be   | ed by             | Tarrin Guide   |  |  |                        | idenying caus    | o givoii  | rii i aiti.             |  |                                   | es 2 🗆                               |  | obably 4 ⊡XInkn   |  |
|   | Completed         |  |  |  |                        |                  |   |                         |  | 24a. Was autop<br>perfor<br>1 Yes | med?                                 | 24b. Were aut<br>prior to d<br>death?<br>1 \( \text{Yes} | topsy findings avails<br>completion of cause<br>2 \( \text{No} \) |  |
| this certifical director.   | Be                | 25. Was case referred to medical examiner?   | Hogoital:  |  |                        |                  |   |                         |  | Check only or                     |                                      |  |   |  |
| this cral dire  | ۵,                | 1 162 5 340  |  |  | ER/Outpatien           |                  | Other   | 4 🗆 14013               |  | ne 5 🗆 Resid                      |                                      |  | rify)   |  |
|   | on:               | 27. Manner of Death 1 Natural 5 ☐ Pending  | 28a. Date of (Month,                                   | Injury<br><i>Day Year)</i>   | 28b. Time of<br>Injury | 1                | Injury a Work?  |                         |  | 8d. Describe h                    | ow injury                            | ccurred  |   |  |
| r death.<br>ector: After<br>by the fune   | Sati              | 2 Accident investigation   |  |  |                        | М                | 1 🗆 Ye  | s 2 No                  |  |                                   |                                      |  |   |  |
| i Sign  | Certification;    | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of<br>building                              | Injury - At h<br>, etc. (Specil  | ome, farm, str         | eet, factory, of | fice  |                         | -                                      | 28f. Location (S<br>City or Tow   | itreet and I<br>n, State)            | Number or Ru   | ral Route Number,   |  |
| within 24 hours after of To the Funeral Direct completely filled in by  | edical C          | (Check only one)   | mician. To the basi<br>iner: On the basi<br>and manner | s of examina   | wladge, death          | estigation, in   | ne time<br>my opir  | data and<br>nion, death | placs a<br>occurre                     | and due to the co                 | ause(s) a<br>date and pl             | d name 18<br>ace, and due                                | stated,<br>to the cause(s)  |  |
| ompl  | Me                | 29b. Signature and title of certifier  | \Ac. 1   | 1 1  |                        | 29c. Li          | cense i   | number                  | -                                      |                                   | 29d. Date s                          | signed (Month  | . Day, Year)  |  |
| 0   |                   | Laymord  | M. We  | ute  |                        | D                | 00  | 439                     | 53                                     | 9                                 |                                      | July 5,  | , 2006  |  |
|   |                   | 30. Name and a ress of person who con Raymond White, M.  |  |  |                        |                  | Sil   | lver :                  | Spri                                   | ng, MD                            | 2091                                 | 0  |   |  |
|   |                   | -  |  |  |                        |                  |   |                         | -                                      | - '                               |                                      |  |   |  |

06-04602 Jesse C. Salvador

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 22818

|   | 1- For State Certificate of Death Reg. No. |   |  |              |                             |                    |            |                         |                        |                                |                        | 0 2201                      |                            |   |
|---|--|---|--|--------------|-----------------------------|--------------------|------------|-------------------------|------------------------|--------------------------------|------------------------|-----------------------------|----------------------------|---|
| Physiciar   | 1  | <ol> <li>Decedent's Name (First, Middle,La</li> </ol>   | •  |              |                             |                    |            | _                       | 2                      | Date of De<br>Month            | ath<br>Day             | Year                        |                            | 3. Time of Death                              |
| edical Examin   |  |   | Caceres  | Sa           | lvad                        |                    |            |                         |                        | July 1, 20                     | 006                    |                             |                            | 0002 hrs                                      |
|   |  | <ol> <li>Facility Name (if not institution, gi</li> <li>1901 Erie Street Apartme</li> </ol>   | ·  |              |                             | City, To<br>Adelph |            | ocation of              | Death                  |                                | - 1                    | c. County of<br>Prince Ge   |                            | 's  |
| F   | 4  | Social Security Number 6. 8   |  | last hirth   |                             | If Under           |            | If Under                | 24Hrs.                 | 8. Date of B                   |                        |                             |                            | nplace (State or                              |
| Funeral<br>Director   | ١  | 040 44 4500   | K <sub>M 2</sub> F 20  | ioot Birti   |                             | Months             | Days       | Hours                   | Min.                   |                                | ,                      | 1                           | Foreigr                    | 1   |
|   | ŀ  | Usual Residence of Decedent   | M 2 F 20   |              | Yrs.                        |                    |            |                         |                        | Aug.                           | / ,                    | 985                         | -Wa                        | sh.,D.C.                                      |
| any   | -  | 10a. State 10b. County  | 10c. Cit   | y, Town o    | or Location                 |                    |            |                         | -                      |                                |                        |                             | Т                          | 10d. Inside City Limits                       |
| <b>*</b> .  | _  | MD Prince   | George's A   | Adel         | .phi                        |                    |            |                         |                        |                                |                        |                             |                            | 1 Yes 2 X No                                  |
| Aaryland<br>28a-f show<br>1 at once.  | Director                                   | 10e. Street and Number  |  |              | 1                           | 0f. Zip C          | ode        |                         |                        |                                | 10g. Cit               | izen of Wha                 | t Coun                     | try?  |
| the M   | 5  | 1701 Keokee St  | reet   |              |                             | 207                | 83         |                         |                        |                                |                        | USA                         |                            |   |
| with ms 23.   | [ -  | 11. Marital Status  | 12. Was Decedent Ever in   | J.S.         |                             |                    |            |                         |                        | cify Yes or N                  | 0-                     |                             |                            | an Indian, Black,                             |
| death<br>or iter  | runerai                                    | 1 X Never Married 2 Marrie  | d Armed Forces?  1 Yes 2 X No                                    |              | ir Yes,                     | specity            | Cuban, r   | Mexican, F<br>F1 S      |                        | vador                          |                        | White,                      |                            | hite  |
| after<br>al", c   | 6  |   | d If Yes, Give Year<br>or Dates:                                 |              | 1 X Y                       | L.m.               |            | specify:                |                        |                                |                        | Specify:                    |                            |   |
| hours<br>natui  |  | 15. Decedent's Education (Specify of  |  |              | Decedent's<br>luring most   |                    |            |                         |                        |                                | 16b. i                 | Kind of Busi                | ness/ir                    | ndustry                                       |
| 36<br>in 72<br>han "  | b b  | Elementary/Secondary (0-12)   | College (1-4 or 5+)  |              | onst                        | ruc                | tio        | n                       |                        |                                | ] ]                    | Roof                        | Co.                        |   |
| d with giene  | Completed                                  | 17. Father's Name (First, Middle, Las   | t)   | _i           |                             |                    | 18         | .Mother's               | Name (                 | First, Middle,                 | Maiden                 | Surname)                    |                            |   |
| 21215-0036  Juld be filed within 72  Mental Hygiene.  To event, the Medical   | ge   | Mario Salvado   | r  |              |                             |                    |            | Mari                    | a D                    | e Jes                          | sus                    | Cace                        | res                        | s Espana                                      |
| 21,7<br>hould the ord Men is mar  | 12   | 19a. Informant's Name/Relationship (  |  |              |                             |                    | (Street a  | and Number              | er or Ru               | ral Route Nu                   | mber, C                | ity or Town,                | State,                     | Zip Code)                                     |
|   | Ŀ  | Mario Salvador  | •  |              |                             |                    |            |                         |                        | Adel                           |                        |                             |                            |   |
| re, ME<br>s.1 and 2 si<br>if Health ar<br>If item 27  |  | 20a. Method of Disposition  1 X Burial 2 Cremation 3  |  |              | f Dispositio<br>ry or other |                    | of ceme    |                         |                        | Date                           | 20c.                   | Location - (                | City or 7                  | Fown, State                                   |
| Page<br>nent o  | ł  | 4 Denation 5 Other Specifi  |  | ate          | e of Heaven 7/06/06 Silve   |                    |            |                         |                        |                                |                        |                             | r S                        | pring,Md                                      |
| Baltimore,<br>permit. Pages 1 ar<br>pepartment of Her<br>Important: If ite  | 1  | 21 Signature of Euporal Indian Lice   | neae   |              | 22. Nam<br>PH 1             | e and A            | ddress o   | f Facility              | AT.D.                  | riin                           | ERΔ                    | L SEI                       | 2 <i>V</i> T               | CE P A  |
| 1   | Ĵ  | pay point   | -liantings that accord the deat                                  | h Do not     | 1924                        | 11 (               | بَلَوْ     | mbia                    | B                      | lvd.S                          | ilv                    | er Si                       | ari                        | ng Md2091                                     |
| Physician<br>/Medical   |  | PHILIP D. RINALDI FUNERAL SERV 9241 Columbia Blvd. Silver Spr  23a. Part I. — ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaf failure. List only one cause on each line. |  |              |                             |                    |            |                         |                        |                                |                        |                             | Between Onset and<br>Death |   |
| ≟xaminer  | ĺ  | Immediate Cause (Final disease or condition resulting in death)   | Multiple Gunshot Wou   |              |                             |                    |            |                         |                        |                                |                        |                             |                            | Deatil  |
|   |  | Sequentially list conditions,   | ).   | 0.7.         |                             |                    |            |                         |                        |                                |                        |                             |                            |   |
|   | ner  | if any, leading to immediate cause. Enter Underlying Cause  | Due to (or as a consequence                                      | of):         |                             |                    |            |                         |                        |                                |                        |                             |                            |   |
|   | Examiner                                   | (Disease or injury that initiated events resulting in death) Last   | Due to (or as a consequence                                      | of):         |                             |                    |            |                         |                        | -                              |                        |                             |                            |   |
| cuted   |  | events resulting in death) Last   | i.   |              |                             |                    |            |                         |                        |                                |                        |                             |                            |   |
| 760, cate be execut physician and he burial - tra   | edical                                     | UNPENDED  | AMENDED  |              |                             |                    |            |                         |                        |                                |                        |                             |                            |   |
| 760, ficate be en graphysician the burial   | >  | IF FEMALE:  | 23c. If yes, outcome of pre                                      |              |                             |                    |            |                         |                        |                                | 23                     | d. Date of d                |                            |   |
| 687<br>certific<br>ading<br>se as t   | <u>a</u> (                                 | 23b. Was decedent pregnant in the past 12 months?   | 1 Live birth 4 Pregnant at time of o                             | 1 11-        | Fetal                       |                    |            | Ectopic p               | regnan                 | Э                              |                        | Month                       | D                          | ay Year                                       |
| Box 687 he death certifing y the attending when for use as t  | Physician                                  | 1 Yes 2 No 9 Unknow   | , L.   | teath 5      | Other                       | (Specif            | у)         |                         |                        |                                |                        |                             |                            |   |
| P.O. E  |  | Part II. Other significant conditions   | contributing to death but not                                    | resulting    | in the und                  | erlying c          | ause giv   | en in Part              | l.                     | 23e. Did                       | tobacco                | use contrib                 | ute to t                   | he cause of death?                            |
| P.O   | g D  |   |  |              |                             |                    |            |                         |                        | 1Y                             | es 2                   | No 3                        | Proba                      | ably 4 <b>Un</b> known                        |
| ords<br>aw requi  | Completed                                  |   |  |              |                             |                    |            |                         |                        | 24a. Was                       |                        |                             |                            | opsy findings available ompletion of cause of |
| ecol<br>ne law<br>te has<br>ge 2 sl   | Ε̈́  |   |  |              |                             |                    | -          |                         |                        |                                | ormed?                 | de                          | ath?<br>✓ Yes              |   |
| tal Rection: The certificate ector, page  |  | 25. Was case referred to medical  |  |              |                             | 26                 | Place o    | f Death (C              | heck or                |                                |                        |                             |                            |   |
| Vital Rec   | o Re                                       | examiner? 1 Yes 2 No  | Hospital: 1 Inpatient 2  | ER/Ou        | tpatient 3                  | DO                 | A 0        | ther <sub>4</sub> I     | Nursing                | Home 5                         | Reside                 | ence 6 🗸                    | Other:                     | Scene   |
| n of ding Ph  | =  | 27. Manner of Death   | 28a. Date of Injury<br>FOUND:                                    |              | ime of Injui                | ´                  |            | at Work?                |                        | 8d. Describe<br>Ubject she     |                        | ury occurre                 | d                          |   |
| ion<br>ttendi<br>leath.<br>tor: /   | atio                                       | 1 Natural 5 Pending 2 Accident Investiga  | 1 nn nnnn  | FOUI<br>2359 |                             |                    | 1Ye        | s 2 🗸 N                 | lo J                   | object on                      |                        |                             |                            |   |
| Division of Vital Records, tal or Attending Physician: The law requints after death.  In Director: After this certificate has been sided in by the funeral director, page 2 should be a built on the funeral director, page 2 should be a | Certification;                             | 3 Suicide 6 Could no  | t be 28e. Place of Injury - At                                   |              |                             | actory, o          | office bui | lding, etc.             | - 1                    | or Town,                       | State)                 |                             |                            | al Route Number, City                         |
| Spital spital nours remaineral  | ဗ် မ                                       | 4 Homicide determin   | (openin) Wilditi-I all   |              |                             |                    |            |                         |                        |                                |                        | - <del>-</del>              |                            | 3, Adelphi, MD                                |
|   |  | 29a. Certifier 1 Certifying Physicone) 2 Medical Examine  | cian: To the best of my knowle<br>er:On the basis of examination | dge, dea     | th occurred                 | at the ti          | me, date   | and place<br>death occu | e, and d<br>irred at f | ue to the cau<br>he time, date | ise(s) ar<br>e and bla | nd manner a<br>ace, and due | s starte<br>e to the       | ed.<br>cause(s)                               |
| Tott<br>withi<br>Tott   | Medical                                    | 29b. Signature and title of certifier   | and manner stated.   |              |                             |                    | License i  |                         |                        | <u></u>                        |                        |                             |                            | th, Day, Year)                                |
| A   |  | // / //   | 71:  |              |                             |                    | O.C.M      |                         |                        |                                |                        | / 1, 2006                   |                            | , = -9, ,                                     |
| <b>"</b>  | -  | 30. Name and address of person who  | completed of sea of death //to                                   | m 22al       |                             |                    |            |                         |                        |                                |                        |                             | _                          |   |
| ļ   | - [  |   | ssistant Medical Examir  |              | 11 Penn                     | Stree              | t, Balti   | more, M                 | 1D 21                  | 201                            |                        |                             |                            |   |
| Sta   | te   | 31 Date filed (Mostle Pay Year)   | 32 Registrar's Signa   |              | book                        |                    |            |                         |                        |                                |                        |                             |                            |   |
| Registr   |  | JUL II h Z  | 006 Mayer  | O- 1         | Company of                  | 1                  |            |                         |                        |                                |                        |                             |                            |   |

|               |  |                     | For<br>State<br>Registrar  | State of Mar  |  | artment of H  |   | , ,                                  | ene<br>1. No. 2006   | 2281   |  |  |  |  |
|---------------|--|---------------------|--|---|--|---|---|--------------------------------------|--|--|--|--|--|--|
|               | Physici<br>/Medic  |                     | Decedent's Name (First, Middle, Last     THOMAS DELMAR   | SMI <b>T</b> H  |  |   |   | 2. Date of Death Month               | Day Year   |  |  |  |  |  |
|               | Examir   |                     | 4a. Facility Name (If not institution, give WASHINGTON COUNT   |   |  |   | r Location of Death<br>HAGERSTOW            | N N                                  | 4c. County of Death WASH   |  |  |  |  |  |
|               | Funeral<br>Director  |                     | 5. Social Security Number 722–18–6080 6. S   | ex 7. Age (i  | n yrs. last birthday)<br>79 Yrs.         | If Under 1 Year<br>Months Days  | If Under 24 Hrs. Hours Min.                 | 8. Date of Birth                     | 9. Birth   | nplace (State or Foreign<br>VIRGINIA                       |  |  |  |  |
|               | death with the Maryland<br>me 23e or 28e-f show<br>final be ricillied at   | Director            | Usual Residence of Decedent  10a. State 10b. County  MARYLAND WASH  10e. Street and Number   | INGTON  | 0c. City, Town or L                      |   | ONSBORO                                     | 100                                  | g. Citizen of What Co  | 10d. Inside City Limits 1 ☐ Yes 2 📉 No untry?              |  |  |  |  |
| 0030          | or its   | by Funeral Di       | 8442 MOUNTAIN LA  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | UREL ROAD  12. Was Decedent Even Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: | 1945– 13.<br>1946                        | Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No                     |   | ecify Yes or No-<br>Rican, etc.)     | U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: WHITE |  |  |  |  |  |
| N-C 7 7       | d within 72 hours<br>giene.<br>Ir than "natural",<br>Ir a Madical Exa  | Completed           | 15. Decedent's Ec<br>(Specify only highest gra<br>Elementary/Secondary (0-12)<br>10  | de completed)  College (1-4or 5+)   | (Give                                    | dent's Usual Occupa<br>skind of work done of<br>DO NOT use retired      | during most of worki                        | ng 16                                | 16b. Kind of Business/Industry  GROCERY STORE                          |  |  |  |  |  |
| /land         | uld be filed withi<br>Mental Hygiene.<br>Inked other than<br>itic event, the M   | To Be C             | 17. Father's Name (First, Middle, Last) THOMAS EARL SMIT   | H   |  | 18. Mother's Name (First, Middle, Maiden Sumame)  ANNIE VIRGINIA MARTIN |   |                                      |  |  |  |  |  |  |
| , Mar         | and 2 should<br>saith and Men<br>n 27 is marke<br>ier treumatic  |                     | 19a. Informant's Name/Relationship (   | WIFE  | 844:                                     | 2 MOUNTAII  | N LAUREL                                    | ROAD, BOO                            | City or Town, State, Z<br>DNSBORO, M                                   | D 21713  |  |  |  |  |
| Imore         | Pages 1 amment of Healt<br>tent: if item 2<br>jury or other  |                     | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify  | Removal from State  | 20b. Place of Disponentery, cre PARKLAWN | osition (Name of matory or other place MEM • PARI                       | (e)   | /2006                                | ROCKVILLE  | own, State  MARYLAND                                       |  |  |  |  |
| Dall          | permit. Pag<br>Department<br>Important:<br>eny injury c  |                     | 21. Signature of Finneral Service Pacer  | ,   | 2  | 2. Name and Address BAST FUN  | was every contraction                       |                                      | NATIONAL<br>RO, MARYLA   | ND 21713   |  |  |  |  |
| /on,          | eath certificate be executed  T Must be a strength and attending physicien and attending certains to a strength and a strength | dicai Examiner      | 23a. P. nt. Enter he diseas — Com shock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a c  | consequence of):                         | al ry   | feel chou                                   | r respiratory arres                  | t.   | Approximate<br>Interval Between<br>Onset and Death         |  |  |  |  |
| O. Box 68     | at the death certificate<br>by the attending phys<br>tached for use as the   | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome of 1 Live birth 2   4 Pregnant at tin 9 Unknown                      | Fetal death 3                            | □Ectopic pregnancy □ Other (specify)                                    | ′   |                                      | 23d. Date of delin   | very<br>Day Year   |  |  |  |  |
| ecords, P.    | signed b   | þ                   | Part II. Other significant conditions of   | ontributing to death but  | not resulting in the u                   | underlying cause giv  | en in Part I.                               | 23e. Did toba                        | cco use contribute to<br>2 ☑ No 3 ☐ Pro                                | the cause of death?  |  |  |  |  |
| итан жесо     | The law<br>ete hes b<br>page 2 sl  | Be Completed        | 25. Was case referred to medical   |   |  |   | 26. Place of Death                          | 24a. Was an autopsy performe 1 Yes 2 | ed?   death?   | oppsy findings available<br>ompletion of cause of<br>2  No |  |  |  |  |
| DIVISION OF V | Attending Physic death.  ector: After this by the funeral dir  | Certification: To E | examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined   |   | 'ear) 28b. Time of Injury                | of 28c. Injun<br>Worl<br>M 1 🗆  | y at k?<br>Yes 2 \( \text{No} \)            | 28d. Describe how                    | et and Number or Ru  |  |  |  |  |  |
| 2             | To the Hospital or within 24 hours after To the Funeral Dir completely filled in   | Medical Cer         | 29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar   | ysician: To the best of e   | camination and/or in                     | th occurred at the tin  | ne, date and place,<br>pinion, death occurr | and due to the cau                   | se(s) and manner as<br>e and place, and due                            | stated.<br>to the cause(s)                                 |  |  |  |  |
|               | To the within ? To the comple  | Mec                 | 29b. Signature and title of certifier  | Veel  | •  | 29c. Licens   |   |                                      | 1. Date signed (Month) 7 _ 10 - 20                                     |  |  |  |  |  |
| 31            | 4-6+1  |                     | 30. Name and address of person who ABDAC WAHE  | completed cause of dea  | th (Item 23a) (Type                      | Print)<br>4KH1(A  | 12. HAGE                                    | RITOWN.                              | MD 2174  | 2_   |  |  |  |  |
| DH            | Sta<br>Regist  | rar                 | 31. Date filed (Month, Day, Year)  JUL 112   | 2006 Registrar  | Signature                                | Jele .  |   |                                      |  |  |  |  |  |  |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** JÜĽY 2ď6 6:30 A M GERTRUDE ANN COATES SMALLWOOD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CHARLES RESIDENCE, 10837 LA PLATA ROAD LA PLATA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** JANUARY 1, Ye 1915 Months Days Hours Min 1□M 20 F MARYLAND 91 Yrs 220-34-4321 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow Examiner must be notified at 1 ☐Yes 21 No LA PLATA MARYLAND CHARLES Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 20646 UNITED STATES 10837 LA PLATA ROAD 238 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: BLACK δ 3 Widowed 4 ☐ Divorced 'naturel' Completed the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SENIOR COMPANION COMMUNITY SERVICE 7TH GRADE other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I OLIVIA JOHNSON DAN SHORTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20646 MARY E. LYLES / DAUGHTER 10837 LA PLATA ROAD, LA PLATA, MARYLAND if Health 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If ite any injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ST. JOSEPH'S CEMETERY JULY 8,2006 POMFRET, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serva Cicansee THORNTON FUNERAL HOME, P.A. LADIA C. THORNION JOHNSON MOO583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DUAN CE Physician ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 1 Yes 2 2 No 2 \ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 AResidence 6 Other (Specify) ို 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturat 5 Pending death. I Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours efter To the Funeral Dire 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signat re and title of certifier 29c. License number 29d. Date signed (Montil, Day, Year) 30. Mame and ad ress of of death (Item 23a) (Tybe, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUL 0 5 2006

|   |  | For State Registrar   |                                  | State of M   | larylan              |                                 | artment<br><i>rtificate</i>                |                               |                          | ind Me      | ental Hy                    | ygiene<br>Reg. No.         | 000                           | 22  | 821         |
|---|--|---|----------------------------------|--|----------------------|---------------------------------|--|-------------------------------|--------------------------|-------------|-----------------------------|----------------------------|-------------------------------|---|-------------|
| 7. m  | 1000   | 1. Decedent's Name (Firs  | t, Middle, Las                   | t)   |                      |                                 |  |                               |                          | 2           | 2. Date of D                |                            |                               |   | of Death    |
| Phys<br>/Me   | iciar<br>dica  | MILL MACI. AIVIE  | IONY SM                          | IITH   |                      |                                 |  |                               |                          |             | July                        |                            | 7 Year<br>2006                | 12:1                                      | 1 A M       |
|   | nine   | 4a. Facility Name (If not in  | -                                |  | )                    |                                 | 4b. City, T                                | own, or L                     | ocation o                | f Death     | -                           | 4c.                        | County of De                  | ath                                       |             |
| 1   |  | Civista M   |                                  |  | no /In wes           | last birthday)                  | La I                                       | Plata                         | If Under 2               | 4 Hrs       | Date of B                   | ieth (                     | Charles                       | irbalass (Ctata                           |             |
| Funer  Directe  |  | 217-72-8278   |                                  | XM 2 F   | 49                   | Yrs.                            |  |                               | Hours                    | Min.        | Month D                     | 13. 1                      | 956 WAST                      | irthplace (State<br>Jountry)<br>HNGICN, D | or r-oreign |
| 2 12  |  | Usual Residence of Dece   |                                  |  |                      |                                 |  |                               |                          |             |                             |                            |                               |   |             |
| arylan<br>show  |  | _   | County                           |  | 10c. Cit             | y, Town or Lo                   | cation                                     |                               |                          |             |                             |                            |                               | 10d. Inside                               | ,           |
| Ba-f  | 100  | MARYLAND  | CHARLES                          |  | LA                   | PLATA                           | 101 7                                      | 01.                           |                          |             |                             | 40. 000                    |                               |   | s 2 No      |
| leath with the Marylan<br>ns 23a or 28a-f show<br>mant be not lied at               | Ž  | 10e. Street and Number 7545 ANNAPOLIS   | woods R                          | $\sigma$   |                      |                                 | 10f. Zip (                                 | 20646                         | 5                        |             |                             | 1115                       | izen of What C                |   |             |
| death with the Maryland<br>ms 23a or 28a-f show                                     | Ciocal Disconn   | 11. Marital Status  | WOODS IN                         | 12. Was Decedent   | t Ever in U.         | S. 13.                          | Was Decede                                 |                               |                          | gin? (Speci | fy Yes or N<br>can, etc.)   |                            | 14. Race - Am                 |   |             |
| P # 8   | ü  | 1 Never Married 2   | ☐ Married                        | Armed Forces   |                      |                                 | f Yes, speci<br>1 ☐ Yes 2                  |                               | Mexican,<br>Specify:     | , Puerto Ri | can, etc.)                  |                            | Black, Wh                     |   |             |
| 2-UUSO<br>72 hours after<br>naturel; or ite   | 1  | 3 Widowed 4 D   | ivorced                          | If Yes, Give<br>Year or Dates:                             |                      |                                 | 10 163 4                                   | <b>A</b> 1 140                | эреспу.                  |             |                             |                            | Specify: BI                   | .ACK                                      |             |
| 0 2 2 3   | Pot of a moo   | 15. D<br>(Specify onl   | ecedent's Ed<br>y highest gra    | ucation<br>de completed)                                   |                      | (Give                           | ient's Usual<br>kind of worl<br>DO NOT use | k done dui                    | on<br>ring most          | of working  | 7                           | 16b. Ki                    | nd of Busines                 | s/Industry                                |             |
| within ene.   | 1  | Elementary/Secondary 11TH GRADE   | (0-12)                           | College (1-4or   | 5+)                  | α                               |  | 9 10(1100)                    |                          |             |                             | FOOD                       | SERVICE                       | ?   |             |
| Hyg<br>other  | 0  |   | Middle, Last)                    |  |                      | 301                             |  | 1                             | 8. Mother                | r's Name (  | First, Middle               |                            |                               | -   |             |
| Vian<br>uld be<br>Aenta<br>rked<br>ric ev   | 9  | SYLVESTER SMITT   | H                                |  |                      |                                 |  | F                             | EARL                     | BERTHA      | CUIRIO                      | OK SMI                     | TH                            |   |             |
| Mary<br>d 2 sho<br>th and h<br>7 is ma  | 1  | 19a. Informant's Name/R   |                                  |  |                      | /1                              | -  |                               |                          |             |                             |                            | r Town, State,                |   |             |
| re, M<br>s 1 and 3<br>f Health<br>item 27<br>other tr                               |  | PEARL B. SMITH  | •                                | R  | 201 5                |                                 |  |                               | JS ROA                   |             |                             | _                          | AND 206                       |   |             |
|   |  | 20a. Method of Dispositio<br>1 XBurial 2 ☐ Crea   |                                  | Removal from State   | 0                    | lace of Dispo<br>emetery, crer  | natory or oth                              | her place)                    |                          | Da          |                             |                            | cation - City o               |   |             |
| Baltimo  bermit. Pages Department of mportant: if if any injury or or               |  | 4 Donation 5 0  |                                  | 10   | Mr.                  |                                 |  |                               |                          |             |                             | ZULO N                     | ANJEMDY,                      | MARYLAN                                   | עו          |
| baltimo permit. Page Department of important: if eny injury or                      | ouce   | LADIA C. TH   | DRIVION J                        | OTHNSON MOO  |                      | 34                              |  | TIVESTO                       | IN KON                   | D, INL      | LAN HE                      |                            | RYLAND                        | 20640                                     |             |
| Physicia<br>/Medic  |  | 23a. Part1. Enter the disc<br>shock, or heart failu<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)                          | ease, or comp<br>re. List only o | a  | d the death<br>line. | . 0                             | er the mode                                | of dying,                     | such as                  | cardiac or  | tespiratory i               | arrest,                    |                               | Approxim<br>Interval B<br>Onset and       | etween      |
| be executed be executed clean and buriat-transit                                    | er   | Sequentially list condition if any, leading to immediacause. Enter Underlying Cause (Disease or righry that initiated events resulting in death) Last | is, atte                         | b. Due to (or as   | 3%                   | uence of):                      | s T  | Te                            | 20                       | ite         | <b>\</b>                    |                            |                               | Je de                                     | ers<br>ers  |
| . U. BOX 68/.  The death certificate by the attending physical ached for use as the | Manual Manual  | IF FEMALE: 23b. Was decedent pregint the past 12 month 1  Yes 2 No 9 Unknown  |                                  | 23c. If yes, outcome 1 Live birth 4 Pregnant a             | 2 Feta               | death 3                         | Ectopic pre<br>Other (spe                  |                               |                          |             |                             | 2                          | 23d. Date of de<br>Month      | elivery<br>Day                            | Year        |
| S, F<br>es that<br>igned to<br>be deta  | 1  | Part II. Other significant  | conditions of                    | ontributing to death                                       | but not res          | ulting in the u                 | nderlying ca                               | use given                     | in Part I.               |             | 100                         | 9                          |                               | to the cause of                           |             |
| COrd  | o de la caración de l |   |                                  |  |                      |                                 |  |                               |                          |             | 24a. Wa:                    | s an                       | 24b. Were a                   | autopsy finding                           | s available |
| age h   | .   8  |   |                                  |  |                      |                                 |  |                               |                          |             | perf                        | ormed?                     | prior to<br>death?            | completion of                             | cause of    |
| VITAL sician: 1 certificet rector, p  | 0  | 25. Was case referred to  | medicat                          |  |                      |                                 |  | 2                             | 26. Place                | of Death (  | 1 Yes Check only            | one)                       | 1 10 10                       | S ZUNO                                    |             |
|   |  | 1 Yes 2 No  |                                  | Hospital: 1   Inpati                                       | ient 2               | ER/Outpatien                    | t 3 🗆 DO                                   | Other:                        | 4 □ Nur                  | sing Home   | 5 🗆 Res                     | idence 6                   | 3 □Other (Sp.                 | ecify)                                    |             |
| After Image   |  |   | Pending<br>investigation         | 28a. Date of Inj<br>(Month, Da                             | ury<br>ay Year)      | 28b. Time of<br>Injury          | M 28                                       | c. Injury a<br>Work?<br>1  Ye | ıt<br>es 2 □ N           |             | d. Describe                 | how injury                 | y occurred                    | -   |             |
| - P# = =  | 1  | 3 Suicide 6 4 Homicide  | Could not be determined          | 286. Place of it   | njury - At ho        | ome, farm, str                  | eet, factory,                              | office                        |                          | 28          | f. Location<br>City or To   | (Street and<br>own, State) | d Number or F<br>)            | Rural Route Nu                            | mber,       |
| To the Hospitel within 24 hours a To the Funerei E completely filled it             | Modical  |   | Cartifying Ph<br>ladical Exem    | ysician: To the best<br>iner: On the basis<br>and manner s | of examina           | wledge, death<br>tion and/or in | occurred a<br>vestigation,                 | it the time,<br>in my opin    | , date and<br>nion, deat | d place, an | d due to the<br>at the time | cause(s)<br>, date and     | and manner a<br>place, and du | as stated.<br>se to the cause             | (s)         |
| To the<br>within<br>To the  | 1  | 29b. Signature and title o  | certifier                        | *  |                      | ai.                             | 29c.                                       | License r                     | number                   |             |                             |                            | _                             | nth, Day, Year)                           |             |
|   |  | DAT   | 1 1                              | the les  | LAN                  | ~ W                             | ) D-                                       | -4604                         | 6                        |             |                             | 7-                         | - 3 -                         | 200                                       | 60          |
| ( == 1.   |  | 30. Name and address of   |                                  |  |                      |                                 |  |                               |                          |             |                             |                            |                               |   |             |
| DB 3:1  |  | Amir a. Mirz  | a Alik                           | hani, MD,  | 101                  | Center                          | nnial                                      | St.,                          | Ste                      | . В,        | LaP1a                       | ta, M                      | ID 2064                       | 6   |             |
| A   | State<br>istra   | 31. Date filed (Month, Da   | y. Year)<br>L 0 5 2              | 32. Jogist   | trar's Signa         | ture                            | all of                                     |                               |                          |             |                             |                            |                               |   |             |

DHMH 17 Rev 1/2001

SMITH

MICHAEL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Catherine A. Scharpf July 2006 0828 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Oct. 28 Birthplace (State or Foreign Country)
 MD Year) 1 □ M 2 🛛 F 215-12-8983 Yrs Director 83 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28e-f show other treumetic event, the Madical Everyings must be notified at Director NOXYes 2 □ No Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13313 Atlantic Blvd. or Items 23g 21842 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Be Completed by 1 ☐ Yes 2 况 No Specify: White 3XXWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent; If item 27 is marked othe any injury or other treumetic event, <u>DIRE</u>. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kenneth McDonough Margaret Merryman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon Scharpf, Jr. 714 MacPhail Ct., N., Bel Air, Md. 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Cape Henlopen Crem. 17-6-06 Frankford, DE 21. Sign ture of Funeral S. VI. Licensee 22. Name and Address of Facility The Burbage Funeral Home enderson M00284 108 William St., Berlin, Md. 21811 233 Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Klebsiella bacteremia with sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): 828 Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Division of Vital 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Tes 2 1 No Director: After this in by the funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 \_Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funerel C 1 - riffying Physic nn: To the cest of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examine. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) peq. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 053612 7/5/06 BAREN 30. Na and address of person who completed cause of death (Item 23a) ype, Print) 32. Jegistrar's Signature Healthway Dr Cerlin, MD 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Gary L. Simms 01 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death YENINSU4 REGIONAL NICOM 100 MEDICAL CENTEX SALISBUR A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 29,1948 Birthplace (State or Foreign Country)
 MD **Funeral** Days 1**X** M 2 ☐ F Hours Director 58 Yrs. 218-48-7457 Usual Residence of Decedent 10c. City, Town or Location A strong and hardene.
and Mental Hygiene.
le marked other than "natural", or liems 23a or 28a-1 ehow
reumatic event, the Medical Examinat must be notified at 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 No Worcester Whaleyville Funeral Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11809 Steam Mill Hill Rd. 21872 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 █XNo þ Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Master Sergeant U.S. Army Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) item 27 is marked o Pages 1 and 2 should be Harrison Duncan ပ Ella Simms Barton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Simms Purnell/sister 304 Mill Pond Lane #135, Salisbury, MD 21804 other Itimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pulletts UMC Cemetery 7/6/2006 Whalevville, MD 21. Signature of Funeral Service Acens 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of physicien Completed by Physician/Medical attending physical for use as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. sete hes been signed by the a page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 Yes 2 No 1 Yes 2 No , or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one | Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name an odress of person who complete th (Item 23a) (Type, Print) EN8. 100 E. CAKKOII 31. Date filed (Month, Day, Year) 32. Raustrar's Signature State Registrar 5 JUL 0

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** FREDERICK LOUIS SCHMIDT 2:30 P<sup>M</sup> 07 2006 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 39 STOYER STREET FROSTBURG ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Days Hours Yrs. **Director** 218 66 4702 51 JULY 2, 1955 MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Importent: If item 27 is marked other then "neture!" ---- any injury or other treumatic average. 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits Yes 2 □ No Directo ALLEGANEY FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? STOYER STREET 39 21532 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FOLDER GRAPHIC DESIGN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROBERT HAROLD SCHMIDT HELEN (DOYLE) SCHMIDT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SCHMIDT/ BROTHER JAMES 111 WOOD STREET FROSTBURG, MD 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) THE CUMBERLAND CREMATORY 7/17/06 CUMBERLAND, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 WEST MAIN STREET moosy/ Sowers funeral home, P.A. Frostburg, MD Dowol 141 23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Esophageal Cancer 6 months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nunknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 1 ☐ Yes 2 No 3 DOA this Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the MO Worsocks 00055325 2066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 48 Tarn Terrace Frestburg WONSOCK SHIN 31. Date filed (Month, Day, Year) State JUL 2 0 2006 Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760

06-04781

# Please Type or Print in Black Indelible Ink

| rustin Lee Smiti  |                | State of Maryland / Department of State of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Cer |  | 70  | eg. No. 2006 2282   |
|---|----------------|--|--|---|---|
| Physici<br>Medical Exami  |                | 1 Decedent's Name (First, Middle,Last)   |  | Date of Dea     Month                           | Day Year  |
| *   | iiiei          | Justin Lee Smith  4a. Facility Name (if not institution, give street and number)   | 4b. City, Town, or Location o                                    | July 6, 20                                      | 4c. County of Death   |
|   |                | Beckleysville Road, 1 mile east of Gunpo   | Freeland   |   | Baltimore County  |
| Funeral<br>Director   |                | $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$   | Months Days Hours  | Min   | th(MM/DD/YYYYY) 9 Birthplace (State or Foreign 21, 1984 Country) PA |
| any   |                | Usual Residence of Decedent  10a State 10b. County 10c. City, Town or Loc  | ation  |   | 10d Inside City Limits  |
| * .   | r              | PA York Railroad   |  |   | 1 X Yes 2 No  |
| Maryland<br>28a-f show<br>1 at once.  | Director       | 10e. Street and Number   | 10f Zip Code   | 11  | 0g. Citizen of What Country?  |
| ith the Maryland<br>23a or 28a-f sho<br>notified at once.   |                | 20 E. Main St.   | 17355  |   | USA   |
| death w   | Funeral        | 1 X Never Married 2 Married Armed Forces? If   | /as Decedent of Hispanic Orig<br>Yes, specify Cuban, Mexican,    | in? ( Specify Yes or No-<br>Puerto Rican, etc.) | - 14 Race - American Indian, Black,<br>White, etc.                  |
| -0036 Authin 72 hours after of within 72 hours after of giene. Then "natural", of Medical Examiner in   | þ              | Tor Dates:   | Yes 2 No specify   | ind of world                                    | Specify white   |
| 2 hour<br>"natu   | ted            | Elementary/Secondary (0-12) College (1-4 or 5+)  | ent's Usual Occupation (Give k<br>most of working life. DO NOT ( |   | 16b Kind of Business/Industry                                       |
| 336<br>thin 72<br>than<br>than<br>edical  | Completed      | 11 lab   | orer   |   | construction  |
| 5-0C<br>led wil<br>Hygier<br>other  | ~ I            | 17. Father's Name (First, Middle, Last)  | 18.Mother's  | s Name (First, Middle, N                        | Maiden Surname)   |
| 21215-0036 Juld he filed within 7 Mental Hygiene. marked other than c event, the Medica   | Be             | Robert W. Smith, Jr.   |  | neebee M. B                                     |   |
| ND 212<br>td 2 should he<br>alth and Menta<br>m 27 is marke<br>aumatic event  | ٢              |  |  |   | ber, City or Town, State, Zip Code)                                 |
| imore, MiD 2 Pages 1 and 2 shou ment of Health and I nant: If item 27 is n or other traumatic   |                | 20a Method of Disposition 20b Place of Dispo   | 6 Bond Rd. sition (Name of cemetery,                             | Parkton, M                                      | 20c. Location - City or Town, State                                 |
| nor6 ages l nt of l it: If i  |                | 1 X Burial 2 Cremation 3 Removal from State crematory or or  |  | 7 12 2006                                       | T-1. D4   |
| Baltimore, I permit. Pages I and Department of Heal Important: If item injury or other tra  |                | 4 Donation 5 Other Specify: Lebanon 21 Signature of Funeral Service Licensee 22  | Name and Address of Facility                                     | 7-12-2006                                       | Felton, PA<br>134 W. Broadway                                       |
| Dept Inju   |                | Supril & Glodelte B  | urg Funeral Ho   |   | Red Lion, PA 17356  |
| Physician   |                | 2 a. Part I. Enter the disease, or complications that caused the death. Do not enter<br>failure, List only one cause on each line.   |  |   |   |
| /Medical  |                | Immediate Cause (Final disease or condition resulting in death)  Dise to (or as a consequence of):   |  |   | Death   |
|   |                | but to (of as a consequence of).   |  |   |   |
|   | Jer            | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  |  |   |   |
|   | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Uue to (or as a consequence of):  |  |   |   |
| executed an and al - transit  |                | d  |  |   |   |
| e exec  | dica           | UNPENDED AMENDED   |  |   |   |
| K 68760,  I certificate be executed ending physician and use as the burial - transi   |                | IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the   |  |   | 23d Date of delivery  |
| OX 68   | cian           | past 12 months?  | etal death 3Ectopic   wither (Specify)                           | pregnancy                                       | Month Day Year  |
| Box 687 e death certific the attending p ed for use as the  | Ş              | 1 Yes 2 No 9 Unknown 9 Unknown   | mier (opcony)  |   | 1   |
| P.O. Bees that the designed by the  | by P           | Part II. Other significant conditions contributing to death but not resulting in the   | underlying cause given in Par                                    |   | pacco use contribute to the cause of death?                         |
| ords, P.C   | ed b           |  |  |   | 2 No 3 Probably 4 Unknown   |
| cords law requi   | plet           |  |  | 24a Was a autops perform                        | y prior to completion of cause of                                   |
| tal Rec<br>tian: The l<br>certificate b   | Completed      |  |  | 1 Yes 2   |   |
| Division of Vital Records, ral or Attending Physician: The law requir rs after death all Director: After this certificate has been sited in by the funeral director, page 2 should be all the funeral director, page 2 should   | Be (           | 25. Was case referred to medical examiner? Hospital: 1 Insertion 2 FB/Outpution  | 26.Place of Death (C   |   |   |
| n of Vi<br>Jing Physi<br>After this<br>funeral dir  | P.             | 1 Yes 2 No Tuspital 1 Inpatient 2 ER/Outpatier 27. Manner of Death 28a. Date of Injury 28b. Time of  |  |   | Residence 6  Other: Scene   |
| ion creating eath the fun   | Ē              | 1 Natural 5 Pending FOUND: POUND:  | 1 Yes 2 🗸 1  | Subject drow                                    | ned while swimming  |
| ivision or Attendafter death Director:  | fica           | 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre   | eet, factory, office building, etc.                              |   | treet and Number or Rural Route Number, City                        |
| Divis Hospital or Av 24 hours after c Funeral Direc   | Certification: | 4 Homicide determined (Specify) Lake   |  | Pretty Boy R                                    | <sup>ate)</sup><br>eservoir, Freeland, MD                           |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should the detached for use as the burit |                | 29a Certifier 1  |  |   |   |
| To the within 2 To the complet  | Medical        | 2 medical Examiner: On the basis of examination and/or investigation and manner stated.  29b Signature and title offcertifier  | 29c. License number  | arred at the time, date a                       | 29d Date signed (Month, Day, Year)                                  |
|   |                | (Yalilana)   | O.C.M.E.   |   | July 7, 2006  |
|   |                | 30 Name and address of person who com Neter cause of death (Item 23a)  |  |   |   |
|   |                | 10000  | n Street, Baltimore, MD  | 21201   | 4   |
|   | ate            |  |  | -   |   |
| Regist  | trar           | OUL 2 U 2000   Marines He As   | call s   |   |   |
| Drivin 17 Rev 1/2   | 001            | ORIGINA  | XL-  |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JULY 13 2006 DORIS F. SHERMAN 1:20a M /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chestertown Nursing & Rehab Chestertown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 29 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 212 F 92 1913 Maryland Director 218-20-7461 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 28a-f show other traumatic svent, the Medical Examiner roust be notified at 1 ☐ Yes 21 No MD Kent Galena Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Itams 23a 31901 Jim Davis Rd. 21635 U.S.A. death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of death and Mental Hygiene. Health and Mental Hygiene. In 27 Is marked other than "natural", or Itsi 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Licensed Practical Nurse Nursing Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Orin Downey Olive Mariner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 (grdaughter) Debra Conner 31901 Jim Davis Rd. Galena, MD. 21635 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/17/06 \* 4 □ Donation 5 □ Other (Specify) Wesley Cemetery Rock Hall, MD. Calena Funeral Home of Stephen L. 118 West Cross St. Galena, MD. 21 Mining of Europe Service L. Schaech 21635 M00510 a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Proysician troke disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ithlerosclavosi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events Due to (or as a consequence of) Examiner burial-transit Due to (or as a lonsequence of) ortangion resulting in death) Last attending physician for use as the burial Box 68760 requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 1 HO Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ MG this funeral c 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier 1 [Descritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated. (Check only one) To ths ! 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 56824 address of person who completed cause of death (Item 23a) (Type, Print) 3

Registrar

Donaher,

JUL 2 0 2005

Pau1 31. Date filed (Month, Day, Year)  $M \cdot D$ .

32 Jegistrar's Signature.

DHMH 17 Rev 1/2001

119 C North Main St. Galena,

MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar #29d, per physician, 7/11/06 Certificate of Death BA, WCHD Amended item Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Joseph longue, & :40 6 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Sallsbur At the Wicomico -oastal ake Hospice If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5/13/1944 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 1**ऑ**M 2□ F 213-42-0769 Director 62 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State worle r than "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Worcester Stockton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 5906 George Island Landing Road 21864 Funeral death 12. Was Decedent Ever in U.S. Amed Forces? MD

13. Y

13. Y

15 Yes, 2 □ No Army

17 Yes, Give

Year or Date National Guard Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed by white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Supervisor Utilities 12 traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental I 2 Frances Irene Nicholson Joseph Tongue, Sr. ဥ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health a important: If item 27 is eny injury or other tra Margaret R. Tongue (wife) 5906 George Island Landing Rd., Stockton, MD 21864 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/10/2006 Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home, P.A CET 103 Linden Ave., Pocomoke City, MD 21851 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Blodde Metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine nding physicien and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I ed by the e 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ 10 24a. Was an 222 No 1 Tes or Attending Physicien: After this certification funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 1 Impatient 1 ☐ Yes 🏞 No 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of eath 28b. Time of 28d. Describe how injury occurred Injury ospitei ... 4 hours after dea.. real Director: Afr Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours to the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and une to the cause(s) and mainle. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel ÷ 29b, Signature and title of certifier 29c. License number 7-6-06

State Registrar

HIL 6 7 2005

31. Date filed (Month, Day, Year)

budl

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Aggistrar's Signature

|  |  |                  | For State Registrar   | State of   | Maryla                 |                                    | artment of F                                  |                                   | d Mental Hy                                | giene 2                          | 006                         | 22828   |
|--|--|------------------|---|--|------------------------|------------------------------------|---|-----------------------------------|--|----------------------------------|-----------------------------|---|
|  |  |                  | 1. Decedent's Name (First, Middle,                                    | Last)  | -                      |                                    |   |                                   | 2. Date of D                               | eath<br>Day                      | Vand                        | 3. Time of Death                              |
|  | Physici<br>/Medic  |                  | Rosie   |  | Ε.                     |                                    | Wat   | son                               | June                                       | 28,200                           | Year                        | 2:30 p <sup>M</sup>                           |
|  | Examin   |                  | 4a. Facility Name (If not institution,                                | give street and numb                                       | er)                    |                                    | 4b. City, Town, o                             | r Location of D                   | Death                                      |                                  | ty of Death                 |   |
|  |  |                  | Charles Count   |  |                        |                                    | LaPlat  |                                   |  |                                  |                             | County  |
|  | Funeral  |                  |   | 6. Sex 7.<br>1 ☐ M 2X ☐ F                                  |                        | s. last birthday)<br>Yrs.          | If Under 1 Year<br>Months Days                |                                   | Min. 8. Date of Bi (Month, D)  May         | 11, 08                           | Cou                         | place (State or Foreign                       |
|  | Director   |                  | 213-42-5420 Usual Residence of Decedent                               |  | 98                     |                                    |   |                                   | riay                                       | , 00                             | Mar                         | ryland  |
|  | yland  |                  | 10a. State 10b. County  |  | 10c. C                 | City, Town or Lo                   | cation  |                                   |  |                                  |                             | 10d. Inside City Limits                       |
|  | Mar  | io               | Maryland Prin   | ce Georg   | е                      | Brand                              | lywine  |                                   |  |                                  |                             | 1 TyYes 2 □ No                                |
|  | or 28  | Funeral Director | 10e. Street and Number  |  |                        |                                    | 10f. Zip Code                                 |                                   |  | 10g. Citizen of                  | What Cou                    | ntry?   |
|  | th wi  | ai               | 14100 Baden   | Westwood   | Rd                     |                                    | 20613   |                                   |  | USA                              | A                           |   |
|  | tems tems  | nue              | 11. Marital Status  | 12. Was Decede<br>Armed Force                              | ∍s?                    | U.S. 13.                           | Was Decedent of H<br>If Yes, specify Cuba     | lispanic Origin<br>an, Mexican, P | ? (Specify Yes or N<br>Juerto Rican, etc.) | o- 14. Ra<br>BI                  | ice - Ameri<br>ack, White,  | etc.  |
| 36   | s afte   | by F             | 1 ☐ Never Married 2 ☐ Marrie<br>3 ☐ Widowed 4 ☐ Divorced              | ed 1 ☐ Yes 2<br>If Yes, Give<br>Year or Date               |                        |                                    | 1 ☐ Yes 2 ☑ No                                | Specify:                          |  | Spec                             |                             | ican  |
| 5-0036   | within 72 hours after death with the Maryland<br>ene.<br>then "neturel", or Items 23a or 28a-f ehow<br>the Madical Examiner must be multified at   | edt              | 15. Decedent's  |  | 15.                    | 16a. Dece                          | dent's Usual Occup                            | ation                             |  | 16b. Kind of                     |                             | dian  |
| 5  | n ne   | Completed        | (Specify only highest<br>Elementary/Secondary (0-12)                  | grade completed)   | a. F. \                | (Give                              | kind of work done<br>DO NOT use retired       | durina most of                    | working                                    |                                  |                             |   |
| 2  | d with   | E                | 12  | College (1-4   | OI 3+)                 | I I                                | Iomemake                                      | r                                 |  | Dor                              | nesti                       | ic  |
| g  | al Hyg   | 3e C             | 17. Father's Name (First, Middle, L.                                  | ast)   |                        |                                    |   | 18. Mother's                      | Name (First, Middle                        | e, Maiden Surna                  | ime)                        |   |
| Maryland 2121  | Ment   | To Be            | Josh  |  |                        | _Watso                             | n   | Mary                              |  |                                  | Tł                          | nomas   |
| lar  | 2 sh<br>and<br>is m  | - 1              | 19a. Informant's Name/Relationshi                                     |  |                        |                                    |   |                                   | r Rural Route Numb                         |                                  |                             | ,   |
|  | and<br>fealth<br>m 27<br>her tr  | 1                | Alice Watson  | / Daught   |                        | -                                  | Baden sition (Name of                         | Westw                             | ood Rd, I                                  |                                  |                             | MD 20613                                      |
| Baltimore,   | ges it of the control of other   |                  | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation                   |  | ate                    | cemetery, crei                     | natory or other plac                          | .                                 |  | 20c. Location                    | -                           |   |
| Ē  | t. Pa<br>rtmen<br>rtant:<br>njury  |                  | 4 Donation 5 Other (Sp.   |  | R                      |                                    | ection C                                      |                                   |  | Clinto                           |                             |   |
| Ba   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertial Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show apportant: If item 27 is marked other then "naturel", or Items 23a or 28a-f show appropriate you other traumatic event. The Medical Examiner must be notified at ODGs. |                  | 21. Signature of Funeral Service E                                    |  |                        | 191 Ad                             |   | eral :                            | 20605 Ad<br>Home PA,                       | Aquas                            | Road<br>sco M               | d<br>MD,20608                                 |
|  |  |                  | 23a. Part1. Ent. the disease, or c<br>shock, or heart failure. List o | nelications that cau<br>nly one cause on eac               | sed the dea<br>h line. | ath. Do not en                     | er the mode of dyin                           | ng, such as car                   | rdiac or respiratory                       | arrest,                          |                             | Approximate<br>Interval Between               |
| The same of the sa | Physician  |                  | Immediate Cause (Final disease or condition                           | . Re   | NE                     | 1 Fa                               | lure  |                                   |  |                                  |                             | Onset and Death                               |
| п  | /Medical<br>Examiner   |                  | resulting in death)   | Due to (or   | as a conse             | equence of):                       | elvre<br>ance                                 |                                   |  |                                  |                             |   |
| ı  | Zammer   | <u>.</u>         | Sequentially list conditions, if any, leading to immediate            |  | as a conse             |                                    | ance  | 7                                 |  |                                  | _                           |   |
|  | led<br>Isit  | Examiner         | cause. Enter Underlying Cause (Disease or injury                      | D09 10 (01   | as a conse             | equerice or/.                      |   |                                   |  |                                  |                             |   |
| _  | xecur<br>and<br>al-tra   | xar              | that initiated events<br>resulting in death) Last                     | c. Due to (or  | as a conse             | equence of):                       |   |                                   |  |                                  |                             |   |
| 8760,  | sate be executed<br>physician and<br>the burial-transit  | dical E          |   |  |                        |                                    |   |                                   |  |                                  |                             |   |
| 9  | ificate<br>g phy<br>as the   | edic             |   | u  |                        |                                    |   |                                   |  |                                  |                             |   |
| Вох  | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit   | Physician/Med    | IF FEMALE:<br>23b. Was decedent pregnant                              | 23c. If yes, outco   |                        |                                    | Testania arasana                              |                                   |  | 23d. D                           | ate of deliv                | ery   |
| о.<br>С  | death  | sicia            | in the past 12 months?<br>1 ☐ Yes 2 ☐ No                              | 4☐Pregnan  | t at time of           |                                    | Ectopic pregnancy Other (specify)             |                                   |  | M                                | lonth                       | Day Year                                      |
| P.O.   | at the   | hys              | 9 □ Unknown   |  |                        |                                    |   |                                   |  |                                  |                             |   |
|  | es th<br>igned<br>be de  | by               | Part II. Other significant condition                                  | s contributing to deat                                     | h but not re           | sulting in the u                   | nderlying cause giv                           | en in Part I.                     |  |                                  |                             | he cause of death?                            |
| פֿב  | w requires t<br>been signe<br>should be  | Completed        |   |  |                        |                                    |   |                                   | - 10                                       | Yes 2 □ No                       | 3 Prot                      | bably 4 Unknown                               |
| Ö  | has b  | nple             |   |  |                        |                                    |   |                                   | 24a. Was                                   | psy                              | pnor to co                  | opsy findings available impletion of cause of |
| E  | cate pag   | ပ်               |   |  |                        |                                    |   |                                   | pen<br>1 ☐ Yes                             | 2 No                             | death?<br>1 ☐ Yes           | 2□ No   |
| ž<br>Š   | iclan: Th<br>certificate<br>rector, pag  | Be               | 25. Was case referred to medical examiner?                            | Hospital:  |                        |                                    | Oth   | or /                              | Death (Check only                          |                                  |                             |   |
| Division of Vital Records,   | Attending Physician: or death. ector: After this certification in the funeral director.  | <u>P</u>         | 1 ☐ Yes 2 ② No  27. Manney of Death                                   | 1 ☐ Inp  |                        | ER/Outpatier<br>28b. Time o        | IL 3 DOA                                      | 4 🗷 Nursir                        | ng Home 5 ☐ Res                            | how injury occu                  |                             | (y)   |
| on   | ding<br>h.<br>After<br>funer   | to               | 1 ☑Natural 5 ☐ Pending<br>2 ☐ Accident investiga                      | (Month,  | Day Year)              | Injury                             | Wor   | k?<br>Yes 2 □ No                  | 200. 200020                                |                                  |                             |   |
| <u>IS</u>  | or Attendater deatl  | flca             | 3 ☐ Suicide 6 ☐ Could no  | ot be 28e. Place of  |                        |                                    | eet, factory, office                          |                                   | 28f. Location                              | Street and Num                   | ber or Rura                 | al Route Number,                              |
| á  | al or a after i Dire   | Certification:   | 4 Homicide  | building   | , etc. (Spec           | cify)                              |   |                                   | City or To                                 | wn, State)                       |                             |   |
|  | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page   | edical C         | 29a. Certifier 1 Certifying (Check only one)                          | Physician: To the be<br>xaminer: On the basi<br>and manner | is of examir           | nowledge, deat<br>nation and/or in | n occurred at the tir<br>vestigation, in my o | ne, date and p<br>pinion, death o | lace, and due to the                       | cause(s) and m<br>date and place | nanner as s<br>, and due to | stated.<br>o the cause(s)                     |
|  | ro the vithin o the omple  | Me               | 29b. Signature and title of certifier                                 |  | 1                      | 0                                  | 29c. Licens                                   | e number                          |  | 29d. Date sign                   | ed (Month,                  | Day, Year)                                    |
|  |  |                  | · ) ( c   | N  | 14                     | 1                                  | 73  | 414                               | 3  | 6/7                              | 9/0                         | 6   |
| Ç  | 35   |                  | 30. Name and address of person w                                      | no completed cause   | of death (Ite          | em 23a) (Type,                     | Print)  | 1 " "                             | -  |                                  | 1/0                         | 0   |
| Ĺ  | 705  |                  | Scott Rifkin, 1   |  |                        | un Blv.                            | , Owings                                      | s Mills                           | , Marylan                                  | .d                               |                             |   |
|  | Sta<br>Registi   |                  | 31. Date filed (Month, Day, Year)                                     | 5 2006 32.8  | istrar's Sigr          | nature                             | 1   |                                   |  |                                  |                             |   |
|  | negisti  | aı               | 301 0   | 0 2000   | ALL .                  | 15 /6                              | DE CL   |                                   |  |                                  |                             |   |

|  |  |                     | For<br>State<br>Registrar   |                            | State of Ma  | aryland              |                              | rtment of F<br><i>lificate of</i> a    |                                     |                                   |  | jiene<br>leg. No. 2               | 106                             | 22829                                |
|--|--|---------------------|---|----------------------------|--|----------------------|------------------------------|--|-------------------------------------|-----------------------------------|--|-----------------------------------|---------------------------------|--------------------------------------|
|  |  |                     | 1. Decedent's Name (First, M  | iddle, Las                 | st)  |                      |                              |  |                                     |                                   | Date of Dea<br>Month                   | th<br>Day                         | Year                            | 3. Time of Death                     |
|  | Physici:<br>/Medic   |                     | Irene Florer  | ice W                      | linder   |                      |                              |  |                                     | 1                                 | uly                                    | -                                 | 2004                            | 2118 M                               |
|  | Examin   |                     | 4a. Facility Name (If not institu   | -                          |  |                      |                              | 4b. City, Town, o                      |                                     |                                   |  | 4c. County                        | of Death                        |                                      |
|  |  |                     | PENINSULA RE  |                            |  | CENT<br>(In yrs. las | ER                           | JA L                                   | 15 PCI                              |                                   | Data of Right                          |                                   |                                 |                                      |
|  | uneral<br>irector  |                     | 5. Social Security Number  216-38 - 8968  Usual Residence of Deceden  | 3                          | ex   | 63                   | Yrs.                         | Months Days                            | Hours                               | Min.                              | Date of Birth<br>(Month, Day<br>ept 23 | Year)                             | Coun                            | lace (State or Foreign<br>try)<br>MD |
| land   | Mo II  |                     | 10a. State 10b. Cou   |                            |  | 10c. City, 7         | Fown or Loc                  | ation                                  | _                                   |                                   |  |                                   | 1                               | 0d. Inside City Limits               |
| Mary   | e di   | to                  | MD V  | Vicom                      | ico  | Ma                   | rdela                        | Springs                                |                                     |                                   |  |                                   |                                 | 1 ZYes 2 No                          |
| th the   | or 28g   | lrec                | 10e. Street and Number  |                            |  |                      | -                            | 10f. Zip Code                          |                                     |                                   | 1                                      | l0g. Citizen of                   | What Coun                       | ntry?                                |
| th<br>Mil  | 23a c  | ain                 | 11540 Old Sch   | 1001                       | Rd.  |                      |                              | 21837                                  |                                     |                                   |  |                                   | JSA                             |                                      |
| (I Z I Z I 3-UU30<br>filed within 72 hours after death with the Maryland | to install and welling righted.  I of result and welling righted in the 23a or 28a-f show the 27 is marked other than "natural", or item 27 is marked other than one other traumatic event, the Madical Examinat must be notified at | by Funeral Director | 11. Marital Status  1 ☐ Never Married 2 ☐ I  3 ☐ Widowed 4 ☐ Moivoi   |                            | 12. Was Decedent & Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates: |                      |                              | as Decedent of H<br>Yes, specify Cuba  | lispanic O<br>an, Mexica<br>Specify |                                   | Yes or No-<br>an, etc.)                | 14. Flac<br>Bla<br>Specif         | ce - Americ<br>ck, White,<br>y: |                                      |
| 72 Po  | natur<br>lical   | Completed           | 15. Dece<br>(Specify only hi  | dent's Ed                  |  | 1                    |                              | ent's Usual Occup                      |                                     | ast of working                    |  | 16b. Kind of B                    | usiness/Ind                     | dustry                               |
| ig i   | Mes  | npie                | Elementary/Secondary (0-1   |                            | College (1-4or 5   | +)                   | life. D                      | O NOT use retired                      | d)                                  | ,                                 |  |                                   |                                 |                                      |
| N pel  | marked other than  | S                   | 11<br>17. Father's Name (First, Mid   | Idlo ( ast)                |  |                      |                              | Job C                                  |                                     | her's Name (Fi                    | ret Middle                             |                                   | ical                            | Care                                 |
| 2 2 3  | 9 0 0 C  | Be c                | Otis Hopkins,   |                            |  |                      |                              |  |                                     | orence :                          |  |                                   | 110)                            |                                      |
| aryida<br>should b   | mark   | 7                   | 19a. Informant's Name/Relat   |                            |  |                      | 19b. Mailing                 | Address (Street                        |                                     |                                   |  |                                   | State, Zio                      | Code)                                |
| ~ ~ 0  | 27 Is m  |                     | Patricia Wind   |                            | ** * *   |                      |                              | Levin Das                              |                                     |                                   |  |                                   |                                 | ,                                    |
| S - 3  | Item 27 I  |                     | 20a. Method of Disposition  |                            |  | 20b. Plac            | e of Dispos                  | ition (Name of atory or other place    |                                     | Date                              |  | 20c. Location                     |                                 | wn, State                            |
| Pages  | nt: F  |                     | 1X Burial 2 ☐ Cremat<br>4 ☐ Donation 5 ☐ Othe   |                            |  |                      |                              | Cemetery                               | 1                                   | 7/8/200                           | 26                                     | Sharpto                           | ו מער                           | MD                                   |
|  | Important: If any injury or pose.  |                     | 21. Signature of Funeral San  | viçe Licer                 | see  |                      | 22.                          | Name and Addre                         | ss of Faci                          | ility                             |  |                                   | J.,, 1                          | . <b></b>                            |
| n 88   | 3 5 5 8  |                     |   | X                          |  |                      | 16                           | ewis N. 1<br>518 West                  | Rd.                                 | , Salis                           | oury,                                  | MD 2180                           | 01                              |                                      |
|  |  |                     | 23a. Part1. Enter the disease shock, or heart failure.  | ist only                   | plications that caused<br>one cause on each lir                          | 10.                  | Do not ente                  | r the mode of dyir                     | ng, such a                          | as cardiac or re                  | spiratory arr                          | est,                              |                                 | Approximate<br>Interval Between      |
|  | ysician  |                     | Immediate Cause (Final disease or condition   | 1000                       | a  | ١                    | Ne12                         | 7311                                   | wy                                  |                                   |  |                                   |                                 | Onset and Death                      |
|  | ledical<br>aminer  |                     | resulting in death)   |                            | Due to (or as  | a consequer          | nce of):                     | 1 4 1 5                                | 101                                 | 0 /                               |  |                                   |                                 | Reall                                |
|  |  | <u>-</u>            | Sequentially list conditions,   |                            | b. Due to (or as   | a consequer          | nce of):                     | yman C                                 |                                     |                                   |  |                                   |                                 | 10.0                                 |
| petr   | Insit  | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | ≺ .                        |  |                      | ,                            |  |                                     |                                   |  |                                   |                                 |                                      |
| J,<br>executed   | n and<br>ial-tra   | Exa                 | that initiated events<br>resulting in death) Last   | - 1                        | C. Due to (or as   | a consequer          | nce of):                     |  |                                     |                                   |  |                                   |                                 |                                      |
| oo / ou,   | physician and<br>s the burlal-transit  | edical              |   | ·                          | d  |                      |                              |  |                                     |                                   |  |                                   |                                 |                                      |
|  | as th  | ledi                | IF FEMALE:  |                            |  |                      |                              |  |                                     |                                   | _                                      |                                   |                                 |                                      |
| O. DOX   | within 24 hours stell death. To the Funerel Director: After this certificate has been signed by the ettending gompletely filled in by the funeral director, page 2 should be detached for use a                                      | Physician/M         | 23b. Was decedent pregnan<br>in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                        | t                          | 23c. If yes, outcome<br>1 □Live birth<br>4 □ Pregnant at<br>9 □ Unknown  | 2 Fetal de           | eath 3 🗆                     | Ectopic pregnancy<br>Other (specify)   | У                                   |                                   |  |                                   | te of delive                    | ery<br>Day Year                      |
| ecords, F.O.   | ned b  | by Pt               | Part II. Other significent con  | ditions c                  | ontributing to death b   | ut not resulti       | ng in the un                 | derlying cause giv                     | en in Pari                          | tl.                               | 23e. Did to                            | bacco use con                     | tribute to th                   | ne cause of death?                   |
| ecords<br>law requires   | an sig<br>uld blu  |                     |   | -                          | End - SX   | 2)8                  | Very                         | Ja                                     | Lest                                |                                   | 1 🗆 Y                                  | es 2□No                           | 3 Prob                          | ably 4 Unknown                       |
| a<br>ĕ<br>ĕ  | 2 sho  | Completed           |   |                            |  | 0                    |                              | )                                      | 1                                   |                                   | 24a. Was a autops                      |                                   | Were autor                      | psy findings available               |
| F a  | ate ha   | E O                 |   |                            |  |                      |                              |  |                                     |                                   | perfor                                 | med*                              | death?                          |                                      |
|  | ertifica<br>ctor,  | Be                  | 25. Was case referred to me examiner?   | dical                      | ,  |                      |                              |  | 26. Pla                             | ce of Death (C                    | heck only on                           | nė)                               |                                 |                                      |
| OT VITA<br>Physician:  | his co   | 2                   | 1 ☐ Yes 2 No  |                            | Hospital: 1 Unpatie  |                      | VOutpatient                  |  | 4 🗆 🗅                               | Nursing Home                      |  |                                   |                                 | )                                    |
| Ing P  | After 1<br>unera   | <u>0</u>            | 27. Manner of Death   |                            | 28a. Date of Inju-<br>(Month, Da)  | y Year)              | 8b. Time of<br>Injury        | 28c. Injur<br>Wor                      | rk?                                 |                                   | Describe h                             | ow injury occur                   | red                             |                                      |
| ISIO<br>Itend  | tor:   | cat                 | 3 ☐ Suicide 6 ☐ Co  | vestigation<br>ould not be | e con Disease disi   | ury - At home        | e farm stre                  |  | Yes 2                               |                                   | Location /S                            | treet and Numl                    | ner or Rura                     | I Route Number,                      |
| DIVISION<br>al or Attending  | d in by  | Certification:      | 4 Homicide de   | termined                   | building, etc  |                      | 0, 141111, 3(16              | et, ractory, onice                     |                                     | 2011                              | City or Town                           | n, State)                         | 70, 0, 1,0,2                    | Triodie Tullibor,                    |
| • Hospit   | within 24 hours effer death.  To the Funerel Director: After gompletely filled in by the fune.   | edicai (            | 29a. Certifier 1 Cert (Check only 2 Med   | ifying Ph<br>ical Exan     | nysician: To the best<br>niner: On the basis of<br>and manner sta        | examination          | edge, death<br>n and/or inve | occurred at the tirestigation, in my o | me, date a<br>opinion, de           | and place, and<br>eath occurred a | due to the c                           | ause(s) and ma<br>late and place, | anner as st<br>and due to       | ated.<br>the cause(s)                |
| 5  | To the   | Me                  | 29b. Signature and title of ce  | rtifier                    |  |                      |                              | 29c. Licens                            | se number                           | 5                                 | 2                                      | 9d. Date signe                    | d (Month,                       | Day, Year)                           |
|  | B  |                     | 30 Namo and addings of  | / \ \ \                    | completed cause of d   | eath (Itc= 7         | 3a) (Turns 17                | Print)                                 | 010                                 |                                   |  | 7/                                | 2/06                            |                                      |
|  | 8  |                     | 30. Name and address of per   | STANT                      | [2 1-  | 350                  | 5.                           | Divish                                 | 1 50                                | † ,                               | 3 mluz                                 | by                                | ND                              | 21801                                |
|  | Sta<br>Regist  |                     | 31. Date filed (Month, Day, Y   | (ear)                      | 2006 32. Registra  | ar's Signatur        | re<br>Ar A                   | and .                                  |                                     |                                   |  |                                   |                                 |                                      |
| DHMH   | 17 Flev 1/2  | 2001                |   |                            | 1000   | ec-tibe              | 15                           | June 1                                 |                                     |                                   |  |                                   |                                 |                                      |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 39,2006 1351 M uhe Carolyn M. Williams /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner lisb Icomico at the Lake Hospice C oasta If Under 1 Year | If Under 24 H/s. | 8. Date of Birth (Month, Day, Ye 6-16-1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 ☐ M 2 🔀 F Yrs. 222-32-3436 82 South Carolina Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at DE. Sussex Laure1 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19956 128 Lakeside Drive USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Š 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home .. Pages 1 and 2 should be filed v tment of Health and Mental Hygia tant: if Item 27 is marked other t ijury or other traumatic event, iii other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank R. Manahan Stella Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1235 Tanehill Lane Cincinnati, Ohio 45212 Carol Williams (Daughter) 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Laurel Hill Cemetery July 3, 2006 Laurel, De. 19956 permit. Page Department Important: ff eny injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hannigan Short Disharoon Funeral Home Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or): Examine ettending physicien and for use as the burial-transit or Attending Physicien: The law requires thet the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day 4☐ Pregnant at time of death 5 Other (specify) ned by the e 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signe 1 be d 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate hes been s irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed? 1□ Yes 2⊅ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ☐ ER/Outpatient 3 ☐ DOA hours after death.

Inerei Director: After this y filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitei within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 026278 30. Name and address of person who completed cau e of death (Item 23a) (Type, Print) Bux 1733 DovidE. Conall. Harpne 31. Date filed (Month, Day, Year) JUL 0 5 32 Segistrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 19:02 PM 5000 Ter 06 /Medical 4a. Facility Natire (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5145640 regional MUSICAL Manico NINGUA If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 100 M 2□F 218-48-Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **ehow** ?? is marked other than "naturel", or iteme 23a or 28a-f ebov traumatic event, the Mudical Examinar must be notified at Director 1 Yes 2 No OMI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Venuc Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 1□ Yes 20 No Specify: þ Specify: Black 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ortant: if Item 27 is marked other than Injury or other traumatic average. Elementary/Secondary (0-12) College (1-4or 5+) OOK permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othwent Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or flural Route Number, City or Town, State, Zip Code) Brothen 5448 Stoneh

20b. Place of Disposition (Name of cemeter), crematory or other place) Stonehave Irginia Beuch Anthon, ITIUG ltimore, Date 20a. Method of Disposition 20c. Jocation - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Olomo Ko 21. Signature of Funeral Service Licensee 22. Name and Address of Facility S sabella Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** LUNGESTIVE LYEART FAILURE /Medical Due to (or as a consequence of): Examiner UABRIOMYO PATIE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physicien a hed for use as the burial-Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year signed by the a d be detached for 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ②Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 1 ☐ Yes

68760 Box o. ۵. Records, page 2 should Vital After this certificete funeral director,

Be Certification: To

Hospital or Attending Physicien: Division of death.

within 24 hours after death To the Funerel Director: , completely filled in by the f To the

State Registrar

Medical

29b. Signature and title of certifier

Hospital: 1 | Inpatient

28a. Date of Injury (Month, Day Year)

11.0.

29c. License number

28c. Injury at Work?

1 □Yes 2 □No

3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) JUL 0 5

25. Was case referred to medical examiner?

1 Yes

27. Manner of Death

2 Accident

3 Suicide

4 - Homicide

(Check only one)

1 Natural

2 🗀 No

5 ☐ Pending

investigation

6 Could not be determined

32. Registrar's Signature

400 E. SHORE

2ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 6 8819a Per Inf (858 8/17/06 JH Contificate of Death

|                     |  |                 | Amend #8&19a Per 1nr 6838 8/17/0  | O JH Cert                                | ificate of                         | Death   | Re                                 | g. No.                       |  |
|---------------------|--|-----------------|---|--|------------------------------------|---|------------------------------------|------------------------------|--|
|                     | Diam'r.  |                 | 1. Decedent's Name (First, Middle, Last)  |  |                                    | -   | 2. Dete of Deeth<br>Month          | Dey Ye                       |  |
|                     | Physicia<br>/Medic   | _               | Betty Jean Smith Wise   |  |                                    |   | July 9                             | , 2006                       | 1225   |
|                     | Examin   | er              | 4a Fecility Neme (If not institution, give street and number)   |  |                                    | 4b. City, Town, or Lo                         |                                    | 4c. County of D              |  |
|                     |  | Or .            | Dorchester General Hos  5. Social Security Number 6. Sex 7. Age   |  | If Under 1 Year                    | Cambr<br>If Under 24 Hrs.                     | 1.dge<br>8. Date of Birth          |                              |  |
|                     | Funeral<br>Director  |                 |   |  | Months Deys                        |   | July 4.                            | Year) 1948<br>1958 M         | Birthplace (State or Foreign Country) aryland      |
| -                   | 88   |                 | Usuet Residence of Decedent   |  |                                    |   |                                    |                              |  |
|                     | how<br>te  |                 |   | IOc. City, Town or Loce                  |                                    |   |                                    |                              | 10d. Inside City Limits  1 □ Yes 2 □ No            |
|                     | Sa-f   | Ç               | MD Dorchester   | н  | ırlock                             |   | 140                                | g. Citizen of Whel           |  |
|                     | 1 2 2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4  | Director        | 123 Gold Rush Lane  |  | 10f. Zip Code                      | 21643   |                                    | g. Citizen of Whei<br>United |  |
|                     | within 72 hours attar daath with the Maryland<br>ana.<br>than "natural", or tlems 23a or 28a-f show<br>the Medical Examiner must be notified at  | Funeral         | 11. Marital Status 12. Was Decedent Ev  | erin U.S. 13 W                           |                                    |   |                                    |                              | American Indian,                                   |
| _                   | tar di   | E               | Armed Forces?  1 Never Married 2 Married 1 Yes 2 No   |  |                                    | Hispanic Origin? (Sp<br>pan, Mexican, Puerto  | Rican, etc.)                       |                              | Vhite, etc.  |
| 21215-0020          | urs a  | Ď               | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Yeer or Detes:  | 11                                       | ∐Yes 2KΩNo                         | Specify:                                      |                                    | Specify:                     | Black  |
| 2-0                 | 72 ho  | Be Completed    | 15. Decedent's Education<br>(Specify only highest grade completed)  | 16a. Decede<br>(Give k                   | nt's Usuel Occu                    | petion<br>during most of work                 | ting 1                             | 6b. Kind of Busine           | ess/Industry                                       |
| 7                   | ithin  | 후               | Elementary/Secondary (0-12) College (1-4or 5+)  | life. DO                                 | o <i>not</i> use retire<br>nemake: | ed)   |                                    | Own Ho                       | ) m e  |
| 7                   | hygiar<br>her th   | S               | 17. Father's Name (First, Middle, Last)   | 1 1101                                   |                                    |   | e (First, Middle, M                |                              |  |
| Baltimore, Maryland | d ba f   | Be              | Oliver Wilkinson  |  |                                    | Essi  | e Mae S                            | mith                         |  |
| 37                  | Shoul<br>nd Me<br>mark   | ၉               | 19a. Informant's Name/Relationship (Type, Print)  | 19b. Mailing                             | Address (Stree                     | t and Number or Rui                           | el Route Number,                   | City or Town, Sta.           | te, Zip Code)                                      |
| Š                   | alth a   |                 | <del>VaNess</del> Wise/Spouse   | 123                                      | Gold l                             | Rush Lan                                      | e, Hurl                            | ock, MI                      | 21643  |
| že,                 | of Had   |                 | 20a. Method of Disposition  | 20b. Place of Disposi<br>cemetery, crema | atory or other pla                 |   |                                    | 0c. Location - City          |  |
| Ĕ                   | Page<br>nant d   |                 | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  | Federal                                  |                                    |   |                                    |                              |  |
| alt                 | parmit. Pagas 1 and 2 should be filad within 72 hours attar death with the Marylan Department of Health and Mantal Hygiana. Important: if itam 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at DDCs. |                 | 21. Signature of Funeral Service Licensee   | 22.                                      | Name and Addr                      | ess of Facility ${\operatorname{Fr}}$ a       | amptom 1                           | Tuneral                      | Home, P.A.   |
| ш                   | 201  |                 | Mustine M. Coal   | $\sim$ $^{21}$                           | .6 N. Ma                           | in St., F                                     | ederalsb                           | urg, MD 2                    | 21632  |
|                     |  |                 | 23a. Part1. Enter the disease, or complications that caused the shock, or heart tailure. List only one cause on each line | ne death. Do not enter                   | r the mode of dy                   | ing, such es cardiac                          | or respiratory arre                | st,                          | Approximate<br>tnterval Between<br>Onset and Death |
|                     | Physician /Medical   |                 | Immediate Cause (Final  | · · · · · · · ·                          | 600 112°                           |   |                                    |                              |  |
|                     | Examiner   | ы               | Immediate Cause (Final disease or condition resulting in death)  Interpretation  a. Interpretation  D  Metalle            |  |                                    |   |                                    |                              |  |
|                     |  | ē               | Meterle   | -/12 Consequ                             | ence of):                          | vs Com  |                                    |                              |  |
|                     | aath cartificata be axecuted<br>attanding physician and<br>I for usa as tha bunal-transit  | edical Examiner |   | ue to (or es e consequ                   |                                    |   |                                    |                              |  |
| o                   | e axe<br>ian ar<br>unal-t  | EX              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury               |  |                                    |   |                                    |                              |  |
| x 68760,            | anificata be axecuted<br>ding physician and<br>sa as tha bunal-transi  | dica            |   | ue to (or as e conseque                  | ence of):                          | _   |                                    |                              |  |
| 9 X                 | ding p   | ₹               | d   |  |                                    |   |                                    |                              |  |
| Bo                  | vraquiras that tha daath o<br>baan signad by tha attan<br>should be datachad for u   | Physician       | Out II Other I will not a distance and the last to death but  | not required in the up                   | dodvice course a                   | iven in Part I                                | 23h Did to                         | hacco use contrit            | bute to the cause of death?                        |
| P.O.                | tha d<br>yy tha<br>achac   | hys             | Part II. Other significant conditions contributing to death but   | not resulting in the disc                | denying cause g                    | IVOITIIT ZICI.                                |                                    |                              | Probably Andrews                                   |
| ري<br>ت             | s that<br>gnad t   | by P            |   |  |                                    |   |                                    |                              |  |
| of Vital Records,   | iquira<br>an sig<br>ould b   | 2               |   |  |                                    |   | 24a. Was ar<br>perform             |                              | 4b. Were autopsy findings available prior to       |
| ecc                 | law re<br>as ba  | pie             |   |  |                                    |   |                                    |                              | completion of cause of death?                      |
| <u> </u>            | Tha<br>ata h<br>paga   | Completed       |   |  |                                    |   | 13Ye                               | s 2)⊴Ho                      | 1 ☐ Yes 2 ☐ No                                     |
| /ita                | Physician: The law raquiras that the death this cartificate has been signed by the attering director, page 2 should be detached for  | Be              | 25. Was case referred to medical examiner?  |  |                                    | thor:   | th (Check only one                 |                              | -  |
| of                  | Physic<br>this c   | . To            | 1 Yes 2 10 10 10 10 10 10 10 10 10 10 10 10 10  | t 2 ER/Outpatient<br>28b. Time of        | 3LI DOA                            | 4 U Nursing H                                 | ome 5 Reside<br>28d. Describe ho   | nce 6 Other (                | Specify)   |
| 5                   | ding i<br>h.<br>Aftar<br>funa  | tou             | 1 Matural 5 Pending (Month, Dey 2 Accident investigation  |  | 28c. Inju<br>W<br>M 1[             | ork?<br>]Yes 2∐No                             |                                    |                              |  |
| Division            | Attanding<br>ar death.<br>ector: Aftar<br>by the fune  | fica            | 3 Suicide 6 Could not be determined 28e. Plece of Injur   | y - At home, ferm, stre                  | et, factory, office                | 9   | 28f. Location (Str<br>City or Town |                              | or Rural Route Number,                             |
| Š                   | ai or /<br>s aftar<br>i Dire   | Certification:  | 4 Homicide Getermined building, etc.  | (Ѕреспу)                                 |                                    |   | City of Town                       | , State)                     |  |
|                     | ospita<br>hours<br>unera   | edical (        | 29a. Certifier (Check only)    Wedical Examiner: On the best of   | my knowledge, death                      | occurred at the i                  | time, date end ptace,<br>opinion, death occur | and due to the ca                  | use(s) and manne             | or as stated. due to the cause(s)                  |
|                     | To the Hospital or Attanding Physician: The law within 24 hours aftar death.  To the Funeral Director: Aftar this cartificata has completely filled in by the funeral director, page 2   | Medi            | one) end menner state   | ed.                                      |                                    | nse number                                    |                                    | d. Date signed (A            |  |
|                     | 5 ¥ 5 00   | 5               | 29b. Signature and title of certifier   |  |                                    | 7924  |                                    | 1-10-06                      |  |
|                     |  |                 | 30. Neme and eddress of person who completed ceuse of dea   | ath (Itam 23a) (Type 5                   |                                    | (   -   |                                    |                              |  |
|                     |  |                 |   |  | 7 0                                | FIRR OBEE                                     | 270                                | 2161                         | 3  |
| 1                   | Sta  | ate             | 31. Date filed (Month, Day, Year) 32. Registrer   | 's Signature                             |                                    |   |                                    |                              |  |
|                     | Registr  | rar             | 12 1 1 2 2 1 1 E  | H Kun                                    | A D                                |   |                                    |                              |  |

State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Robert William Willis I /Medical 07 09 2006 5:15 P 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** Corsica Hills Nursing Home Centreville
Under 1 Year | If Under 24 Hrs. Queen Anne Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign Country) Pennsylvania Date of Birth (Month, Dev. Year) **Funeral** Days 1⊠M 2□F Hours Min 60 Director 170-36-9798 11/28/1945 Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland 10a. State 10b County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examinar must be notified at 1 Yes No Director MD Caroline Henderson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16840 Henderson Road / Lot 175 21640 U.S.A. or items 23e Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces:
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1972-76 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Firefighter U.S. AirForce 12 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be fill Department of Heelth and Mental Hy Importent: If Item 27 ie marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ James William Willis Florence Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Willis II/ son 13700 Judson Road/ Lot 131; San Antonio, TX 78233 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Chesapeake Cremation 7/12/2006 Chester, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Helfenbein Funeral Home, PA 160; 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner ospital or Attending Physician: The law requires that the death certificate be executed hours after death. Anores later death. Anores Director: After this certificate has been signed by the attending physicien and yi filled in by the furneral director, page 2 should be detached for use as the burian-transit resulting in death) Last P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 dUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) 30 Name and address of person who completed cause of death them Ave Centrenlle MD 21617 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 10:29,0M UNIC 30 2006 /Medical 4b. City, Town, or Location of Death 4c, County of Death 4a. Fecility Name (If not institution, give street and number) Examiner S Himor A NAI If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Qay 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or I 6. Sex **Funeral** Months Days Hours 240-44-1360 1 M 200 F Yrs. Director Usual Residence of Decedent tha Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State parmit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryla Department of Health and Mantal Hygians. important: if item 27 is marked other then "netural; or items 23s or 28s-f show any injury or other treumatic event, the Medical Evantillar Interpretation of the recities at once. 1 es 2 No Director WAIKER, MARY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 DNo
If Yes, Give
Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₺ No Specify Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) apal 12 18. Mather's Name (First, Middle, Maiden Sumame) Father's Name (First, Middle, Last) Be mwell 0 19a. Informant's Name/Relationship (Type, rint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Other (Specity) 4 Denation 335 / Rocky of Funeral Service Licensee 22. Name and Address of Facility 21. Signature N1:2780 au Part . Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line Approximate Interval Between Onset and Death Preumoni A Immediate Cause (Final disease or condition resulting in death) AS DIRation Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attanding physician and for usa as tha burial-transit or Attending Physician: The law raquiras that the death cartificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Medical Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) datached 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 110 eas ! tra 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No UMON cartificata neral Director; Aftar this cartific fillad in by tha funaral director, 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 1 Yes 2 No 2 FVOutpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending within 24 hours after death.

To the Funeral Director: All complately filled in by the fu 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) USICI D0054558 who completed cause of death (Item 23a) (Type, Print) 30. Name in address of pers BA I times Belvetere Ave JE MD 240 (8DER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 0 2006 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year Yeatman Beryl 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL 3ALBSUM MEDICAL CENTER NICOMICO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year, 5/28/1926 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2 F Min 215-20-0725 80 Pennsylvania Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at X Yes 2 No Director Maryland Salisbury Wicomico 10f. Zip Code 21804 10g. Citizen of What Country? USA 10e. Street and Number death with 1509 Old Ocean City Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: <u>ک</u> white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene. important: If Item 27 ie marked other then 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edith Purnell William B. Jarman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1509 Old Ocean City Rd., Salisbury, MD 21804 Dorothy Ann Yeatman/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/3/06 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD of Funeral Service Licensee DDC. Name and Address of Facility
Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CFSP 501 Snow Hill Rd., Salisbury, MD 21804 Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chuon's /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in dealh) Last Due to (or as a consequence of) certificate be executed burial-transl Due to (or as a consequence of): Box 68760 ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown sete has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No certificete 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2<del>□</del> No 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 1 Tyes this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funerei Director: Af death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 1 Tartifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7(3(06 wo nd address of person who completed cause of death (Item 23a) (Type, Print) 1346 1. Disision . 1. 10 Kay MO 32. Bijistrar's Signature 31. Date filed (Month) State Registrar

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** July 11:13 P M 17 2006 Valerie Denise Allen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Gilchrist Center 8. Date of Birth (Month, Day, Year Oct. 7, 19 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. Months 1□M 2\ F Massachusetts 44 1961 Director 027-54-1021 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r then "naturel", or iteme 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20724 USA 3503 Flatwater Place Funeral within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1XXNever Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 CXNo Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th 4 Software Consultant Computer 7 is marked other traumatic event, I 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be f h and Menta! h Edward Allen Viola Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Depertment of Health ar
Important: If item 27 is
eny injury or other trau David Burgess/Companion 3503 Flatwater Place, Laurel, MD 20724 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3XXRemoval from State 7/25/2006 4 ☐ Donation 5 ☐ Other (Specify) Lakeside Memorial Palmetto, GA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or learnt allure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or condition resulting in death) Ponaldson Funeral Home, F.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 313 Talbott Avenue, Laurel, MD Approximate Interval Between Onset and Death **Physician** car /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Examine ng physicien and as the burial-transit The law requires that the death certificate be executed € 68760, ≪ Due to (or as a consequence of) Physician/Medical attending p Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a Ö 9 Unknown ۵, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4 Unknown this certificate has been si ral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1☐ Yes of Vital or Attending Physicien: : After this certification funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Injury 1 Natural 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deett To the Funeral Director: completely filled in by the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital tig Centrying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)25205 uns who completed cause of death (Item 23a) (Type, Print) Balto Md Zo Zok N- Charles St. 6701 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 2 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner een TVe Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** NOV. 20, 19 Days Min Hours 213-30-7010 Usual Residence of Decedent 1 ☐ M 2 🛛 F Yrs. Director filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 1 Yes 2 □ No Director Nary and more 10f. Zip Code 10g. Citizen of What Country? 5 een 2120 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natursi", or 1 ☐ Yes 2 No Specify Specify: Black Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) stodiai 0 Government permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 9DC. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumane) Be 2 19a. Informant's Name/Relationship (Type, Print) granddaughte )19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Lisa 3alto Md. 2/206 SCOR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State 2006 4 ☐ Donation 5 ☐ Other (Specify) remator 21. Signature of Funeral Service Licensee Name and Ad ress / Facility
Joseph
2222 W. North Ave. Balto Md. 2121 23a. Part / Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho is, or heart fail fre. List only one cause on each line. Approximate sho k or heart fail-immediate Cause (Final disease or condition resulting in death) Interval Between Onset and Death Myoc Physician /Medical Due to (or as a consequence of): Examiner Fortier Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq ence of): Examiner ed by the ettending physicien end detached for use as the burial-transit Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Dunknown 1∏Yes 2∏No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Morbid Obesit 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 1 🗌 Yes 2 PM0 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of La 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred or Attending Injury 1 Patural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation hours after death uneral Director: the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral L the Hospitei 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12005702

State Registrar

31. Date filed (Month, Day, Year) DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

106

32. Begistrar's Signature

Philadelphia Ld.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month MAVIS MARIE APPLER 4:45 20,2006 4c. County of Death /Medical JULY\_ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WESTMINSTER NURSING HOME WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2√2 F 216-03-1921 93 10/3/1912 NORTH CAROLINA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD CARROLL WESTMINSTER Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 616 WOODSIDE DR. 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XNo Specify: If Yes, Give Year or Dates: Completed by Specify: 3X Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOME MAKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOSEPH DAMON COLLINS MATTIE HONEYCUTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES PETERSON -DAUGHTER 621 Woodside Dr., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State MEADOW BRANCH CEM. 7/24/06 WESTMINSTER, MD Donation 5 Other (Specify) uperal Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau Final /year disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and little of TWA parte Rd Westruster 31159 se of death (Item 23a) (Type, Print) Name and address of person who complete Say, Year) L 2 1 State 2006

Registrar DHMH 17 Rev 1/2001

**Funeral** 

Director

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Health and Mental Hygiene.

permit. Pages I Department of H Important: If ite any injury or ot once.

Physician

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neral Director: A

To the Funeral

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funeral director

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

|  |   |                  | State of Manuard   |  |   |                                     | _               | Die.                       |  |
|--|---|------------------|--|--|---|-------------------------------------|-----------------|----------------------------|--|
|  |   |                  | 1 State of Maryland  | Certificate of                                       |   |                                     | 211             | 0.6                        | 22839  |
|  |   | _                | Registrar  1. Decedent's Name (First, Middle, Last)  | Certificate  | Dealli  | 2. Date of Dea                      | th              | 00                         | 3. Time of Death                                 |
|  | Physici   | an               |  |  |   | Month                               | Day             | Year                       | 11.50 A.M.                                       |
|  | /Medic  |                  | Shirley Mae Abbott  4a. Facility Name (If not institution, give street and number)   | Ab City Town   | m, or Location of Death                           | July                                | 4c. Count       | cc (C                      | [r.30]T.".                                       |
|  | Examin  | ier              | Baltimore Washington Med Ct  |  | Burnie  |                                     | Anne            |                            | ndo1   |
|  | Funeral   |                  | 5. Social Security Number 6. Sex 7. Age (In yrs. last  | birthday) If Under 1 Ye                              | ear If Under 24 Hrs.                              | 8. Date of Birth                    |                 |                            | place (State or Foreign ntry)                    |
|  | Director  |                  | 217-34-0149 <sup>1□M 2</sup> F 69  | Yrs. Months Day                                      | ys Hours Min.                                     | 8. Date of Birth (Month, Day 07/10/ | 1937            | Coui                       | ntry) MD   |
| -                                      | D   |                  | Usual Residence of Decedent  |  |   |                                     |                 |                            |  |
|  | irylar<br>show  | _                |  | own or Location                                      |   |                                     |                 | 1                          | 10d. Inside City Limits                          |
|  | death with the Maryland<br>me 23a or 28a-f ehow   | Funeral Director |  | cley Glen  |   |                                     |                 |                            | 1 ☐ Yes 2 🛣 No                                   |
|  | ith th  | E E              | 10e. Street and Number   | 10f. Zip Cod   |   | 1                                   | log. Citizen of |                            | ntry?  |
|  | ath w   | <u>ca</u>        | 101 1st Avenue   | 210  |   |                                     | U.S             |                            |  |
| 1.                                     | er de<br>Item   | E                | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  | 13. Was Decedent of<br>If Yes, specify C             | of Hispanic Origin? (Sp<br>Cuban, Mexican, Puerto | pecify Yes or No-<br>Rican, etc.)   |                 | ce - Americ<br>ick, White, | can Indian,<br>etc.                              |
| 36                                     | rs aft  | by F             | 1 ☐ Never Married 2 Married 1 ☐ Yes 2 Married 1 ☐ Yes (Sive 1 Year or Dates:   | 1 ☐ Yes 2 <b>⊠</b> 1                                 | No Specity:                                       |                                     | Specif          | fy: W                      | hite   |
| 2 8                                    | hou   | ed               |  | 6a. Decedent's Usual Oc                              | ccupation   |                                     | 16b. Kind of B  |                            |  |
| € ±                                    | iin 72<br>n " n   | plet             | (Specify only highest grade completed)   | (Give kind of work do<br>life. DO NOT use re         | one during most of work<br>stired)                | king                                |                 |                            | 303.19   |
| A 2121                                 | l with<br>liene.  | Completed        | Elementary/Secondary (0-12) College (1-4or 5+)   | Clerical   |   |                                     | Acc             | ount                       | ina  |
| 4 0                                    | et to   | Bec              | 17. Father's Name (First, Middle, Last)  |  | 18. Mother's Nam                                  | e (First, Middle,                   |                 |                            |  |
| <u> </u>                               | fenta<br>fenta<br>rked<br>rice  | ToB              | Frederick O. Evans, Jr.  |  | Lillian   | n M. Ha                             | nnan            |                            |  |
| EY ABB 077<br>Maryland 21215-0036      | permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Insperment of Health and Mental Hygiene. Inspertment of Health and Mental Hygiene. Inspertment: if term 27 is marked other then "natural; or iteme 23a or 28a-f ehow eny injury or other traumatic event, the Madical Examinar mast be notified at once.   | [                | 19a. Informant's Name/Relationship (Type, Print)   | 19b. Mailing Address (Stre                           | reet and Number or Rui                            | ral Route Number                    | r, City or Town | , State, Ziç               | Code)  |
|  | alth a  |                  | Henry L. Evans/Brother   | 85 208th   | Street, I   | Pasaden                             | a, MD           | 211                        | 22   |
| HA]                                    | item<br>other   |                  | 20a. Method of Disposition 20b. Place  | e of Disposition (Name of etery, crematory or other) | f<br>place)                                       | Date                                | 20c. Location   | - City or To               | own, State                                       |
| 7 1                                    | Page<br>nent c<br>int: if   |                  | Tabulal 2 Contation 3 Challoval from State   | Haven Me   |   | 20/06                               | Glen :          | Burn                       | ie, MD   |
| <b>₩</b>                               | mit.<br>pertm<br>porta<br>y inju  |                  | 21. Signature of Forneral Septice Licensee   |  | dress of Facility G                               |                                     |                 |                            |  |
| ′ 🛱                                    | Deperm<br>Deperment of the poor o |                  | The Bear   |  | iera Driv   |                                     |                 |                            |  |
|  |   |                  | 23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.  |  |   |                                     |                 |                            | Approximate<br>Interval Between                  |
|  | Physician   |                  | Immediate Cause (Final disease or condition  | enal to  | dine  |                                     |                 |                            | Onset and Death                                  |
|  | /Medical  |                  | resulting in death)  a. Due to (or as a consequent   | ce of):  | ou Me   |                                     |                 | -                          |  |
|  | Examiner  |                  | Sequentially list conditions b. Millautes )  | noslitus   |   |                                     |                 |                            |  |
|  | п =   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | 7  |   | 1                                   | . 4             |                            |  |
|  | ecute<br>ind<br>trans   | E                | trial initiated events   | te condu   | Vinnalan  | heart                               | disen           | al.                        |  |
| 760.                                   | te be exe<br>ysicien a<br>le burial-  |                  | resulting in death) Last Due to (or as a consequent  | ce of):  |   |                                     |                 |                            |  |
| 876                                    | law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit  | lical            | d  |  |   |                                     |                 |                            |  |
| Division of Vital Records. P.O. Box 68 | Attending Physician: The law requires that the death certifica r death.  sctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the  | by Physician/Med | IF FEMALE:   |  |   |                                     | - 14            | 1                          |  |
| BO                                     | ath c<br>attenc   | lan/             | 23b. Was decedent pregnant in the past 12 menths? 23c. If yes, outcome of pregnancy  | ath 3 □Ectopic pregna                                |   |                                     |                 | ate of delive<br>onth      | ery<br>Day Year                                  |
| Ö                                      | the s   | yslc             | 1 Yes 2 No 9 Unknown 9 Unknown   | n 5 ☐ Other (specify,                                | /)  |                                     |                 |                            |  |
| م                                      | thet ti   | F.               | Part II. Other significant conditions contributing to death but not resulting  | o in the underlying cause                            | given in Part I.                                  | 23e. Did to                         | bacco use con   | tribute to t               | he cause of death?                               |
| ds.                                    | sign<br>d be  | ğ                |  |  |   | 1 🗀 Y                               | es 2 No         | 3 🗌 Prot                   | oably 4 🗀 Unknown                                |
| Ö                                      | y requ  | ete              |  |  |   | -                                   |                 |                            |  |
| e<br>E                                 | he lav  | Completed        |  |  |   | 24a. Was a autops perior            | SV              | prior to condeath?         | ppsy findings available<br>impletion of cause of |
| <u></u>                                | n: Th   |                  | OF Western distribution of the last of the |  |   | 1 Yes                               | 2 No            | 1 ☐ Yes                    | 2 No   |
| <u> </u>                               | sicia<br>certi  | Be               | 25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER   | Outpatient 3 DOA                                     | Other: A Churcian Ma                              |                                     |                 |                            |  |
| ō                                      | Phy<br>r this   | 5                | 27. Manner of Death 28a. Date of Injury 28   | Outpatient 3 DOA                                     | njury at<br>Work?                                 | ome 5 Reside                        |                 |                            | <u>y)</u>  |
| 0                                      | ding<br>th.<br>Afte   | ig i             | 1 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation   |  | Work?<br>1 ∐ Yes 2 ∐ No                           |                                     | ,               |                            |  |
| įsi                                    | Atter<br>dea<br>octor   | flea             | 3 Suicide 6 Could not be   | , farm, street, factory, offi                        | ice   | 28f. Location (S                    | treet and Numi  | ber or Run                 | al Route Number,                                 |
| á                                      | i Dire  | Certification:   | 4 Homicide determined building, etc. (Specify)   |  |   | City or Town                        | n, State)       |                            |  |
|  | spit<br>hours<br>nere<br>y fille  | a                | 25s Certifier (K Certifying Physician: To the best of my knowle  | dga, death prouned at the                            | e fline, date and place.                          | and due to the o                    | ause(s) and m   | arvier as s                | tated.   |
|  | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page  | Medical          | (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.  | and/or investigation, in m                           | ny opinion, death occur                           | red at the time, d                  | ate and place,  | and due to                 | the cause(s)                                     |
|  | To the within to the transfer of the transfer     | Σ                | 29b. Signature and title of certifier  | 29c. Lice  | ense number                                       | 2                                   | 9d. Date signe  | d (Month,                  | Day, Year)                                       |
|  | 4   |                  | Mp.  | D  | 43977   | 13                                  | Inles           | 17                         | 2006   |
|  | 10  |                  | 30. Name and address of person who completed cause of eath (Item 3   | a) Type, Print)                                      | 11  | ,                                   | 2222            | 537                        | 220  |
|  | V   |                  | moun Clayung. D. Hose To   | Dure   | ully 50   | me                                  | MD              | 11                         | 161  |
|  | Sta   |                  | 31. Date filed (Month, Day, Yéar) 32. Registrar's Shadature  | 4 / 4.   |   |                                     |                 |                            |  |
|  | Registr   | ar               | JUL 2 1 2006 Magne A   | 7 Boards   |   |                                     |                 |                            |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician 18, 2006 July James Lawrence Ayers /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Memorial Hospital Havre De Grace Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 23.1932 5. Social Security Number 6. Sex 14 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 219-28-1285 73 Director CA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County IT is marked other than "natural", or items 23a or 28a-f ebov traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MD Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Greenway, Apt. 112 USA Peges 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. snt: If item 27 is marked other than "natural; or Itema 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Esther E. Feller James E. Ayers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health at Important: if item 27 is any injury or other traingnities. Veronica Kilmeyer- Daughter 384 Blythedale Rd., Port Deposit, MD 21904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Cem. 7-20-06 Middle River, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home, 21. Signature of Funeral Service Licensee PA, 2134 Willow Spring Road, 21222 Approximate Intervat Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) arrest **Physician** minutes /Medical Due to (or as a consequence of) Examiner Pintarchia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably + Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending To the Hospital or Attendi within 24 hours efter death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave Havre De Groce 5. 501 ONO W 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar DHMH 17 Rev 1/2001

|                     |  | -                 | For<br>State<br>Registrar   | State of N                    | Maryland /                | -                       | tment of H                            |                                  | Mental Hyg                            | ienę<br><sub>eg. No</sub> .2 () | 06                                      | 22841   |
|---------------------|--|-------------------|---|-------------------------------|---------------------------|-------------------------|---------------------------------------|----------------------------------|---------------------------------------|---------------------------------|---|---|
|                     |  |                   | Decedent's Name (First, Middle, Last  | )                             |                           | -                       | ***                                   |                                  | 2. Date of Dea<br>Month               | th<br>Day                       | Year                                    | 3. Time of Death                              |
|                     | Physicia<br>/Medic   |                   | Evelyn Eleanor  | Butt                          |                           |                         |                                       |                                  | July                                  | 18, 2                           | 2006                                    | 7:47 A M                                      |
|                     | Examin   |                   | 4a. Facility Name (If not institution, give                                     | street and numbe              | r)                        |                         | 4b. City, Town, or                    |                                  | h                                     |                                 | ty of Death                             |   |
|                     |  |                   | 9725 Cross Road   | -                             | A // land h               | n internal              | Pero<br>If Under 1 Year               | LY Hall  If Under 24 Hrs         | 9 Date of Birth                       |                                 | utimo                                   |   |
|                     | Funeral<br>Director  |                   | 5. Social Security Number 6. Se 116-12-7996                                     | х<br>]м 2 <b>(X</b> ) F       | Age (In yrs. last b<br>85 | Yrs.                    | Months Days                           | Hours Min.                       |                                       | Year 921                        | Cour                                    | place (State or Foreign<br>ntry)<br>.ULand    |
|                     |  |                   | Usual Residence of Decedent   |                               |                           |                         |                                       |                                  | 7.40.000                              | , ,,_,                          | 1.100 0                                 | greetta                                       |
|                     | yland  |                   | 10a. State 10b. County  |                               | 10c. City, To             | wn or Loc               | ation                                 |                                  |                                       |                                 | 1                                       | 10d. Inside City Limits                       |
|                     | Ba-f   | cto               | Maryland Baltim   | ore                           |                           | Per                     | ry Hall                               |                                  |                                       |                                 |   | 1 ☐ Yes 2 🕱 No                                |
|                     | or 28  | Directo           | 10e. Street and Number  | ,                             |                           |                         | 10f. Zip Code                         | 01106                            | 1                                     | 0g. Cilizen of                  |   | ntry?   |
|                     | • 23e  | rai               | 9725 Cross Road   | 12. Was Deceder               | et Ever in III S          | 12 14                   | as Docadent of Hi                     | 21128                            | Consider Vac or No.                   |                                 | S.A.                                    | can Indian                                    |
|                     | ter de   | Funerai           | 11. Marital Status 1 ☐ Never Married 2 ☒ Married                                | Amed Force                    | s?                        | lf lf                   | Yes, specify Cuba                     | n, Mexican, Puer                 | Specify Yes or No-<br>to Rican, etc.) | Bla                             | ack, White,                             | etc.  |
| 920                 | urs a  | by                | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates | •                         | 1                       | □ Yes 2💢 No                           | Specify:                         |                                       | Speci                           | ity: Who                                | ite   |
| 21215-0036          | 72 ho  | eted              | 15. Decedent's Edu<br>(Specify only highest grad                                | ication<br>le completed)      | 16                        | (Give k                 | ent's Usual Occupa                    | luring most of wo                | rking                                 | 16b. Kind of I                  | 3usiness/In                             | dustry  |
| 7                   | be filed within 72 hours after deeth with the Maryland ital Hygiene and the file of the fi | Completed         | Elementary/Secondary (0-12)   | College (1-40                 | or 5+)                    |                         | ONOT use retired<br>ing Inst          |                                  |                                       | Bowlin                          | ia All                                  | ou.   |
| Б                   | Hygie<br>Hygie<br>ther t   | ပ္ပိ              | 17. Father's Name (First, Middle, Last)   |                               |                           | 5000                    | eng more                              |                                  | me (First, Middle,                    |                                 |   |   |
| au                  | d be dental  | To Be             | James Peters  |                               |                           |                         |                                       | Barbar                           | a Nova                                | ık                              |   |   |
| ary                 | should<br>ind Men<br>marke<br>umatic   | -                 | 19a. Informant's Name/Relationship (T   | ype, Print)                   | 15                        | 9b. Mailing             | Address (Street a                     | and Number or R                  | ural Route Numbe                      | r, City or Town                 | n, State, Zip                           | Code)   |
| ž                   | and 2<br>Balth a<br>n 27 le  |                   | Mr. Jacob Butt  | (husband                      |                           |                         |                                       |                                  | ry Hall,                              |                                 |   |   |
| ore                 | of He<br>of He<br>fitem  | 1.50              | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐                         | Removal from Sta              | 20b. Place<br>cemer       | of Dispos<br>tery, crem | ition (Name of<br>atory or other plac |                                  | Date                                  | 20c. Location                   |   |   |
| Ĕ                   | Peges<br>Iment of I<br>tant: If its<br>jury or o   |                   | 4 □ Donation 5 🗴 Other (Specify   | Entombme                      | ent Bel                   | Air N                   | lem'l Mau                             |                                  | 1/2006                                |                                 |   |   |
| Baltimore, Maryland | permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 le marked other then *returel', or Iteme 23a or 28a-f show emporant: If item 27 le marked other then *returel and item Andical Examinat must be notified at ance; injury or other treumatic event, the Medical Examinat must be notified at ance.   |                   | 21. Signature of Funeral Service Licens   | o Ri                          | nek                       |                         |                                       |                                  | himunek F<br>Baltimore                |                                 |   | <i>'</i> .S                                   |
|                     |  |                   | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of |                               | a line                    |                         |                                       |                                  |                                       |                                 | , [                                     | Approximate<br>Interval Between               |
|                     | Physician  |                   | Immediate Cause (Final disease or condition                                     | . Adve                        | onced                     | De                      | mentic                                | with                             | Failure                               | to the                          | RIVE                                    | Onset and Death  UR                           |
| 1                   | /Medical<br>Examiner   |                   | resulting in death)   | Due to (or                    |                           |                         |                                       |                                  |                                       |                                 |   | 110   |
|                     | LAdminer   | - G               | Sequentially list conditions, if any, leading to immediate                      | b. Due to (or                 | as a consequence          | ON C                    | with                                  | weigr                            | 1/077                                 |                                 | -                                       | 91  |
|                     | ted<br>nsit  | nine              | Cause (Disease or injury  | Ano                           | ask la                    |                         |                                       |                                  |                                       |                                 |   | 41  |
| <u>,</u>            | execu<br>n and<br>ial-tra  | Examin            | that initiated events<br>resulting in death) Last                               | C. Due to (or                 | as a consequence          | e of):                  |                                       |                                  |                                       |                                 |   |   |
| 8760,               | certificate be executed nding physicien and use as the burial-transit  | cal               |   | a 1149                        | phagi                     | a                       |                                       |                                  |                                       |                                 |   |   |
| 9                   | - 40   | Physician/Medical | IF FEMALE:  |                               |                           |                         |                                       |                                  |                                       |                                 |   |   |
| Вох                 | death certifi<br>le attending<br>ed for use as   | lan/              | 23b. Was decedent pregnant in the past 12 months?                               |                               | 2 ☐ Fetal dea             |                         | Ectopic pregnancy                     |                                  |                                       |                                 | ate of delivers.<br>Nonth               | ery<br>Day Year                               |
| P.O.                | he de<br>the a   | ysic              | 1 Yes 2 No  | 4 □ Pregnani<br>9 □ Unknowr   | I at time of death<br>n   | 2                       | Other (specify)                       |                                  |                                       |                                 |   |   |
|                     | res that the de<br>signed by the<br>be detached  |                   | Part II. Other significant conditions of  | ontributing to deat           | h but not resulling       | g in the un             | derlying cause give                   | en in Part I.                    | 23e. Did to                           | bacco use co                    | ntnoute to t                            | the cause of death?                           |
| rds                 | requires<br>seen sign<br>hould be  | d by              | Dencessio   | n, He                         | per7                      | ten.                    | SION                                  |                                  | 1 🗆 Y                                 | es 2□No                         | 3 🗌 Prot                                | bably 4 Honknown                              |
| 000                 | > 4  | ojete             |   | /                             | /                         |                         |                                       |                                  | 24a. Was autop                        | an 24b                          | . Were auto                             | opsy findings available ompletion of cause of |
| Vital Records,      | o  | Completed         |   |                               |                           |                         |                                       |                                  | perfor                                | med?                            | dealh?                                  | 2 <b>5</b>                                    |
| ital                | ystcian: Th<br>is certificete<br>director, pag   | BeC               | 25. Was case referred to medical examiner?                                      |                               |                           |                         |                                       | 26. Place of De                  | ath (Check only o                     | ne)                             |   |   |
| of \                | S 5 5  | ဥ                 | 1 ☐ Yes 2 ►No   | -                             | atient 2 ER/              | _                       |                                       | 4   Industrig                    | Home 5 Resid                          |                                 |   | fy)   |
| N C                 | Jing P   | on                | 27. Manner of Death 1 Natural 5 ☐ Pending                                       |                               | Day Year)                 | b. Time of<br>Injury    | 28c, Injur<br>Wor<br>M 1              | yat<br>k?<br>Yes 2 □No           | 28d. Describe h                       | ow injury occi                  | nrea                                    |   |
| Division            | Attending r death.   | ficat             | 2 Accident investigation 3 Suicide 6 Could not be determined                    |                               | Injury - Al home,         | , farm, stre            |                                       | 7                                |                                       |                                 | nber or Rur                             | al Route Number,                              |
| Ö                   | effer<br>effer<br>Dire   | Certification:    | 4 Homicide  | building                      | , etc. (Specify)          |                         |                                       |                                  | City or Tow                           | m, State)                       |   |   |
|                     | To the Hospitel or Attending Phwithin 24 hours efter death. To the Funeral Director: After the completely filled in by the funeral   | edicai (          | 29a. Certifier 1 Certifying Ph<br>(Check only one)                              |                               |                           |                         | and the second second                 | at at a second a second a second | command and after a first or          |                                 |   |   |
|                     | To the within 2. To the Complet  | Med               | 29b. Signature and title of certifier   | 0                             |                           | Λ                       | 29c. Licens                           | e number                         | 10                                    | 29d. Date sign                  | ned (Month,                             | Day, Year)                                    |
|                     |  |                   | + allen   | Keils                         | lu N.                     | 10                      | 05                                    | 474                              | -9                                    | 10/4                            | 20                                      | 2006  |
| -                   | 6  |                   | 30. Name and address of person who  | completed cause               | ol death (Item 23         | a) (Type, I             | Print)                                | Conce                            | Road                                  | Boil                            | 1 fin                                   | Day, Year)  ZOOC  ACC, MD                     |
|                     | St   | ate               | 31. Date filed (Month, Day, Year)   | 3 Reg                         | istrar's Signature        | 21                      | of my                                 | 01033                            | 140445                                | 201                             | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |   |
| 2                   | Regist   | rar               | JUL 2 1 200   | 10 1200                       | ver si.                   | 1                       |                                       |                                  |                                       |                                 |   |   |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
ALBINA V. BONAR 2. Date of Death July 18 2006 ear 4:00 A M Physician /Medical 4a. Fecility Neme (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heart Heritage Harford Street 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 7.8 | Wonths | Days | Hours | Min. | 8. Date of Birth March 16,1928 Maryland 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F 78 220-20-1732 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-i show the Medical Examiner must be notified at Harford MD Abingdon 1 ☐ Yes 2 No Funeral Director 10f. Zip Code 21009 10e. Street and Number 10g. Citizen of What Country? 1452 Valley Forge Way USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
White 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify Be Completed by 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore Gas and Electric Company Elementary/Secondary (0-12) 12 College (1-4or 5+) Hygiene. Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be flik Department of Health and Mental Hy Important: If Item 27 is marked oth eny injury or other traumatic event Pietro Villa Marianna Provini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Rock-Daughter 1452 Valley Forge Way-Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 7-24-06 Parkville, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS FUNERAL CHAPEL 21050 3 Newport Drive-Forest Hill, Maryland tadden margo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** clonsony /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ triknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only ŝ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPAMIS W. MACPHOIL 615 31. Date filed (Month, Day, Year) 2. Registrar's Signature 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 115 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month John Wayne Bucklew, Sr. July 20, 2006 12:25 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1313 Old Eastern Avenue, Apt. B Baltimore Essex 8. Date of Birth (Month, Day, Year) Sept. 14,1957 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1**X** M 2 □ F Months Days Yrs. Director 212-70-1358 48 Marvland Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location Show 10d. Inside City Limits ir then "natural", or itsms 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Essex 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1313 Old Eastern Avenue, Apt. B 21221 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes, 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽXNo Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Machinist Dairv other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be nd Mentai marked o Bucklew Unknown 2 Pages 1 and 2 should Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t Health 327 Shagbark Road, Middle River, Maryland 21220 Rose Marie Bucklew (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State July 24, 0 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc Baltimore, Maryland 2006 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signature of Fineral Service License uan 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SMAIN COLL LUN cure aurs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires thet the death certificate be executed are has been signed by the ettending physicien and burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the d IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ţ Month Dav Year 4□Pregnant at time of death 5 Other (specify) signed by the e d be detached f 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icete has been sig , page 2 should b Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificete **¾**[XNo 1 ☐ Yes 1 Yes 2 No Attending Physician: After this certification funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one Other: 4 Nursing Home 5 NResidence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes ZXNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1XX\Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident completely filled in by the within 24 hours efter deat To the Funsrs! Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö ro the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 217714 10 30. Name and address of person death (fem 23a) (Type, Print) J'MBVML 4440 IZATER AVE BAJIMER IND LINE PURIOU MILHARL 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

2006

|          |   |                  | 1 - For<br>State<br>Registrar  | State  | of Marylai  | nd / Depa                        | artmer<br>rtificat                    | nt of H             | ealth a<br>Death          | and M                 |                                   | giene<br>Reg. No.      | 006                        | 2              | 284                               | ÷                     |
|----------|---|------------------|--|--|---|----------------------------------|---------------------------------------|---------------------|---------------------------|-----------------------|-----------------------------------|------------------------|----------------------------|----------------|-----------------------------------|-----------------------|
|          | Physici   | an               | Decedent's Name (First, Middle   | , , , ,  |   |                                  |                                       |                     |                           |                       | 2. Date of De<br>Month            | Day                    | Yea                        | ar             | 3. Time of Death                  |                       |
|          | /Medic  |                  | Margaret   |  |   |                                  |                                       | <del></del>         |                           |                       | July                              | 19,                    | 2006                       |                | 1:15 P                            | М                     |
|          | Examin  | ner              | 4a. Facility Name (If not institution Manor Care Du]   |  | imber)  |                                  | _                                     |                     | Location of               | of Death              |                                   |                        | County of D<br>Baltir      |                |                                   |                       |
| 1 :      | Funeral   |                  | Social Security Number   | 6. Sex   | 7. Age (In yrs  | . last birthday)                 | 1.                                    | wSON<br>r 1 Year    | If Under                  | 24 Hrs.               | 8. Date of Bir                    | th                     |                            |                | e (State or Fore                  | ian                   |
|          | Director  |                  | 245-36-0304  | 1□ M 2▼F   | 7   |                                  | Months                                | Days                | Hours                     | Min.                  | Dec 14                            | y, Year)               | 30 N                       | Country        | e (State or Fore<br>Caroli        | <sub>'9''</sub><br>ทล |
|          | 2   |                  | Usual Residence of Decedent  |  |   |                                  |                                       |                     |                           |                       |                                   | ,                      |                            |                |                                   |                       |
|          | ehov  | 2                | 10a. State 10b. County   | <i>,</i> ,                                       | 10c. C  | ity, Town or Lo                  |                                       |                     |                           |                       |                                   |                        |                            | 10d.           | Inside City Lim  1 Yes 2 1        |                       |
|          | 28e-f   | ecto             | Maryland N/  | A  |   | Ва.                              | Ltimo                                 |                     |                           |                       |                                   | 40: 000                |                            |                | 21                                |                       |
|          | MID A   | ā                |  |  |   |                                  |                                       | 2 <b>1</b> 202      | 2                         |                       |                                   | 10g. Citiz             | en of What                 | Country        | 7                                 |                       |
|          | illed within 72 hours after beath with the Maryland<br>Hygiene<br>ther than "naturel", or Items 23a or 28e-f ehow<br>ent, the Medical Examinar must be notified at  | Funeral Director | 1200 Turpin La   | 12. Was Dec                                      | edent Ever in U   | J.S. 13.                         |                                       |                     |                           | ain? (Sp              | ecify Yes or No                   | )- 1                   | USA<br>4. Race - A         | merican        | Indian.                           | _                     |
| 0        | or Ite  | 五                | 1 ☐ Never Married 2 ☐ Marr   | Armed F  | orces?<br>2 X No  | 1                                | _                                     |                     |                           | , Puerto              | ecify Yes or No<br>Rican, etc.)   |                        | Black, W                   | /hite, etc     |                                   |                       |
| 200      | ours.   | d by             | 3 X Widowed 4 ☐ Divorced   | If Yes, G<br>Year or                             | Dates:  |                                  | 1 🗆 Yes                               | 2XI No              | Specify:                  |                       |                                   |                        | Specify:                   | Blac           | k                                 |                       |
| ה ה      | "natu   | Completed        | 15. Deceden<br>(Specify only higher  | 's Education<br>at grade completed               | )   | 16a Dece<br>(Give                | kind of we                            | ork done o          | turina mos                | t of work             | ing                               | 16b. Kir               | d of Busine                | ss/Indus       | stry                              |                       |
| <b>V</b> | than<br>than  | d L              | Elementary/Secondary (0-12)  |  | (1-4or 5+)  |                                  | DO NOT I                              | se retired          | )                         |                       |                                   | Ш                      | ~~ <u>*</u>                |                |                                   |                       |
|          | Hygi<br>Hygi<br>Sther   | ပိ               | 17. Father's Name (First, Middle,  | Last)  |   | INU                              | ırse                                  |                     | 18. Mothe                 | r's Name              | e (First, Middle,                 |                        | spita.<br>Sumame)          | <u> </u>       |                                   |                       |
| 0        | Mental  | To B             | Unk.   |  |   |                                  |                                       |                     |                           | ibe2                  | e Wilso                           | n                      | ,                          |                |                                   |                       |
| מו       | and N<br>mail   | -                | 19a. Informant's Name/Relations  | hip (Type, Print)                                |   | 19b. Maili                       | ng Addres                             | s (Street a         |                           |                       | al Route Numbe                    |                        | Town, Stat                 | e, Zip Co      | ode)                              |                       |
| Σ :      | s 1 and 2 should be bled within 72 hours after death with the marylan if Health and Mental Hygiene. If the state of the marked other than "naturel", or Items 23a or 28e-f ehow other treumatic event, it a Medical Examiner must be notified at  |                  | Lucy Johnson, G  | oddaughte  | er  | 1200                             | Turp                                  | in La               | ne B                      | alti                  | more, M                           | arvl                   | and 21                     | 1202           |                                   |                       |
| . עב     | of He   |                  | 20a. Method of Disposition   | 3 Removal from                                   |   | Place of Dispo<br>cemetery, cre  | osition (Na                           | me of               |                           | [                     | Date                              | 20c. Loc               | ation - City               | or Town        | , State                           |                       |
| Ě        | Pages<br>ment of<br>ant: If it<br>ury or o  |                  | 4 Donation 5 Other (S  |  | Me  | tro Cre                          | emato                                 | cy Ir               | nc. [                     | 07/2                  | 0/06                              | Ba                     | Ltimon                     | e, l           | Maryland                          | f                     |
| baitimor | permit. Pages Department of Important: If it ony injury or one  |                  | 21. Signature of Funeral Service Thomas Grego  | Licenson   | -   | 2:                               | 2. Name a<br>Crema                    | nd Addres           | s of Facility Soc         | ietv                  | Of Mar                            | vlano                  | l.Inc.                     |                | d 21228                           |                       |
|          | 4020 d  |                  | 23a. Part 1. Enter the disease, or   |  | saveed the dea  | uth Donat on                     | 299                                   | Frede               | rick                      | Roa                   | d Balti                           | more                   | Mary                       | land           | 1 21228                           |                       |
| ŧ E      | Physician<br>/Medical<br>Examiner   | ner              | shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | a<br>Due to                                      | Prog  | gence of):                       | re                                    |                     | ech                       |                       |                                   |                        |                            |                | terval Between<br>nset and Death  |                       |
| ,00/00,  | to one pospital or Attending Prosiding. The law requires that the death certificate be executed within 24 hours after deeth, within 24 hours after deeth.  To the Funeral Director; After this certificate has been signed by the attending physicien and *Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. | edical Examiner  | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last  | cDue to  | (or as a conse  | 000                              | sim                                   |                     |                           |                       |                                   |                        |                            |                |                                   |                       |
| .O. DOX  | w requires that the death certific<br>been signed by the attending p<br>should be detached for use as I   | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 1 ☐Live  | utcome of pregr<br>birth 2 Fet<br>nant at time of<br>nown | al death 3                       | ⊒Ectopic p<br>⊒ Other (s <sub>i</sub> |                     |                           |                       |                                   | 2                      | 3d. Date of<br>Month       | delivery<br>Da | y Year                            |                       |
| cords, r | quires that<br>an signed b<br>utd be dett   | by               | Part II. Other significant condition   | ons contributing to                              | death but not re  | sulting in the u                 | nderlying (                           | ause give           | en in Part I.             |                       |                                   | obacco us              |                            | e to the d     | cause of death?                   | ٧n                    |
| ם שבו    | oete has be<br>page 2 sho   | Completed        |  |  |   |                                  |                                       |                     |                           |                       |                                   |                        | 24b. Were prior death      | to compl<br>1? | findings availated on of cause of | ole<br>f              |
| 1011     | Sertific<br>Betor,  | Be               | 25. Was case referred to medical examiner?   |  |   |                                  |                                       |                     |                           | of Death              | (Check only o                     | ле)                    |                            |                |                                   |                       |
| 5        | this dir  | 2                | 1 ☐ Yes 2 ☐ No 27. Manner of Death   |  |   | ER/Outpatie                      |                                       |                     | 462190                    |                       | me 5 Resid                        |                        |                            | (pecify)       |                                   |                       |
| 5        | After<br>After<br>funer   | tl on            | 1 DNatural 5 ☐ Pendin  | 9  | nth, Day Year)  | 28b. Time o<br>Injury            | м                                     | 28c. Injury<br>Work | rat<br>⟨?<br>Yes 2.∐      |                       | 28d. Describe h                   | now injury             | occurred                   |                |                                   |                       |
| DIVISION | To the hospital of Attending Priysician. The law within 24 hours after the form the Funeral Director; After this certificate has completely filled in by the funeral director, page 2.  | ertification:    | 2 Accident investig  | not be 28e. Place                                | e of Injury - Ath<br>ling, etc. (Spec                     | nome, farm, st                   |                                       |                     | 163 2                     |                       | 28f. Location (S<br>City or Tox   |                        | Number or                  | Rural R        | oute Number,                      |                       |
|          | ne nospita<br>n 24 hours<br>he Funera<br>pletely fille  | edical C         | 29a. Certifier 1 Certifyir (Check only 2 Medical one)  | g Physician: To th<br>Examiner: On the<br>and ma | e best of my kn<br>basis of examin<br>nner stated.        | owledge, deat<br>ation and/or in | h occurred<br>vestigation             | at the tim          | e, date an<br>pinion, dea | d place,<br>th occurr | and due to the<br>ed at the time, | cause(s) a<br>date and | and manner<br>place, and c | as state       | ed.<br>e cause(s)                 |                       |
|          | withi<br>To t   | ×                | 29b. Signature and title of certifie   | 00   |   |                                  |                                       | c. License          | _                         |                       |                                   |                        | signed (Mo                 |                |                                   |                       |
|          |   |                  | 1  | 4MM  |   | MD                               |                                       | 1) 31               | 464                       |                       |                                   | 7                      | 201                        | 0 (            |                                   |                       |
|          | 3   |                  | 30. Name and address of person SHOALT A. HA  | who completed cau                                | se of death (Ite  | m 23a) (Type,                    | Print)                                | 25                  | onite                     | 10                    | OF BA                             | LTIM                   | TONE                       | MI             | 2/20                              | (                     |
|          | Sta<br>Registi  |                  | 31. Date filed (Month, Pay, Year)  | 2006   | Selection of  | 15 Ag                            | and !                                 |                     |                           |                       |                                   |                        |                            |                |                                   |                       |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July **Physician** 2006 1:15 p м Evelvn Virginia Bradlev /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JAN 27 1965 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 N F 41 215-90-4978 MD Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. fnside City Limits ?7 is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whaf Country? 13 Fens Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔯 No Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify ٩ If Yes, Give Year or Dates: Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Deli Clerk Grocerv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental ? is marked of Robert Henry Bradlev Pauline Munson ဂ္ Hattie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health at Important: If item 27 is sny injury or other trau Mack Bevel - companion 13 Fens Court, Baltimore, MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date unk 20c. Location - City or Town, State unkcemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD M00986 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Finat disease or condition resulting in death) renal disease **Physician** STAGE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed burial-transit Exami Due to (or as a consequence of): anding physicien use as the burial Box 68760 Physician/Medical this certificate has been signed by the attending in director, page 2 should be detached for use as IF FEMALE: 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulfing in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ ARCULAN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Oafe of fnjury (Month, Day Year) 28b. Time of 28c. Injury af Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Pface of fnjury - Af home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and little of gertifier 29c. License number 29d. Date signed (Month, Day, Year) 25200 20, 2006 cause of Jeath (Item 23a) (Type, Print) Balto Md

State Registrar

6701 Relei 31. Date filed (Month, Day, Year) 32. Registrar's Signature

2006

|                   |   | •                | 1 - For Amend item#28a,p  | State of Ma<br>erME, g858,8                                 | aryland /<br>8/2/06 TT           | Depa<br><i>Cer</i>      | rtment<br>tificate             | of He             | ealth a<br>Death           | and M                    | ental H                             | ygie<br>Reg.      | ne<br>No.2 11 11 6                       | 22846                                 |
|-------------------|---|------------------|---|---|----------------------------------|-------------------------|--------------------------------|-------------------|----------------------------|--------------------------|-------------------------------------|-------------------|--|---------------------------------------|
|                   |   |                  | Decedent's Name (First, Middle, Last)   |   |                                  |                         |                                |                   |                            |                          | 2. Date of D                        | eath              | 000                                      | 3. Time of Death                      |
|                   | Physici   |                  | Dawn Maureen  | Badger  |                                  |                         |                                |                   |                            |                          | July 1                              | 3.                | 2006 Year                                | 2:02 a M                              |
|                   | /Medic<br>Examin  |                  | 4a. Facility Name (If not institution, give s   |   |                                  |                         | 4b. City, To                   | wn, or            | Location o                 |                          |                                     |                   | 4c. County of Death                      |                                       |
|                   | LAGITIII  | CI               | Gilchrist Hospice   |   |                                  |                         | Tow                            | son               |                            |                          |                                     |                   | Baltimore                                | 2                                     |
|                   | Funeral   |                  | 5. Social Security Number 6. Sex  | 7. Age  | e (In yrs. last b                | irthday)                | If Under 1                     | Year              | If Under 2                 | 24 Hrs.                  | 8. Date of E                        | lirth             |  | place (State or Foreign               |
|                   | Director  |                  | 215–62–4119   | ]M 2⊠F  | 56                               | Yrs.                    | Months I                       | Days              | Hours                      | Min.                     | 8. Date of E<br>(Month, I<br>June 2 | 29,               | 1950 Vir                                 | intry)<br>jinia                       |
|                   | D .   | }                | Usual Residence of Decedent   |   | 10a City Tay                     |                         | nation.                        |                   |                            |                          |                                     |                   |  | 40d Incide City Limits                |
|                   | anyla<br>•hov   | <u>_</u>         | Maryland Howard   |   | 10c. City, Tov                   |                         | ation                          |                   |                            |                          |                                     |                   |  | 10d. Inside City Limits 1 ☐ Yes 2√ No |
|                   | Ba-f  | ecto             |   |   | COTUI                            | wila -                  | 1404 7:- 0                     |                   |                            |                          |                                     | 1.0-              | Citizen of Min at Co                     |                                       |
|                   | within 72 hours after death with the Maryland<br>ene.<br>than "naturel", or items 23s or 28s-f ehow<br>he Medical Exeminar must be notified at                    | Funeral Director | 10e. Street and Number  |   |                                  |                         | 10f. Zip C                     |                   |                            |                          |                                     |                   | Citizen of What Co                       | intry?                                |
|                   | s 23  | eral             | 5495 Bluecoat Lane  | 12. Was Decedent (  | Ever in U.S.                     | 13 V                    | 2104                           |                   | enanie Orie                | nin? (Sne                | cify Yes or N                       |                   | JSA<br>14. Race - Amer                   | ican Indian                           |
|                   | Item d  | Ä                | 11. Marital Status  1 Never Married 2 Married   | Armed Forces?   |                                  | lf.                     | Yes, specify                   | Cubar             | n, Mexican                 | , Puerto I               | Rican, etc.)                        | •0-               | Black, White                             |                                       |
| 36                | irs af  | by               | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:                              |                                  | 1                       | ☐ Yes 2€                       | <b>X</b> No       | Specify:                   |                          |                                     |                   | Specify: Whi                             | .te                                   |
| 21215-0036        | 2 hot   | ted              | 15. Decedent's Edu  | cation  | 16a                              |                         | ent's Usual                    |                   |                            |                          |                                     | 16t               | o. Kind of Business/l                    |                                       |
| 215               | hin 7   | be               | (Specify only highest grade<br>Elementary/Secondary (0-12)  | e compietea)<br>College (1-4or 5                            | i+)                              | life. C                 | kind of work<br>OO NOT use     | retired)          | uring most                 | or workii                | ng                                  |                   |  |                                       |
| 21                | giene.  | Completed        |   | 4   | R€                               | gist                    | ered                           | Nur               | se                         |                          |                                     | St                | . Agnes H                                | ospital                               |
| B                 | Main Hy   | Be (             | 17. Father's Name (First, Middle, Last)   |   |                                  |                         |                                |                   |                            |                          | ,                                   |                   | den Sumame)                              |                                       |
| yla               | Ment<br>Ment<br>Prke  | 2                | James T. Boyle  |   |                                  |                         |                                |                   |                            |                          | rginia                              |                   |  |                                       |
| Maryland          | 2 should be filed v<br>n and Mental Hygie<br>ie marked other t<br>rsumatic event, III   |                  | 19a. Informant's Name/Relationship (Ty  | •   |                                  |                         |                                |                   |                            |                          |                                     |                   | ity or Town, State, Z                    | ip Code)                              |
|                   | Bact  |                  | William Douglas Ba  | ager-husb   | 20b. Place                       |                         |                                |                   | Lane,                      |                          | umbia,                              | -                 | ID 21045                                 | O                                     |
| 0                 | ges if of it  |                  | 20a. Method of Disposition  Burial 2 Cremation 3 P  | Removal from State  | cemete                           | ery, crem               | natory`or other                | er place          |                            |                          |                                     |                   | . Location - City or I                   |                                       |
| Baltimore,        | permit. Pages 1 al<br>Department of Hea<br>Important: If Item<br>eny Injury or othe<br>pnca.  |                  | 4 Donation 5 Other (Specify)  |   | Eglin                            | The committee of        | n Ceme                         |                   |                            |                          | 2006                                |                   | .arksboro,                               |                                       |
| Bal               | permit. Pages: Department of the important: if ite eny injury or ot once.   |                  | 21. Signature of Funeral Service License  | 90  |                                  | Ž                       | Vitzke                         | Fu                | neral                      | Hom                      | es, IN                              | IC.               | bia, MD 2                                | 1045                                  |
|                   |   |                  | 23a. Part1. Enter the disease, or compli  | ications that caused  | the death. Do                    |                         |                                |                   |                            |                          |                                     |                   | wiaj in z                                | Approximate<br>Interval Between       |
|                   | Physician   |                  | shock, or heart failure. List only or<br>Immediate Cause (Final   | _   | -                                | T                       | . /                            |                   | of a                       | Lin                      | 10 5                                | 1                 | +-                                       | Onset and Death                       |
| 7                 | /Medical  |                  | disease or condition resulting in death)  | Due to (or as   | a consequence                    | of):                    | 0                              | 9                 | - ( )                      | 1,0                      | 2 3                                 | 1 /1              | 16                                       | minga                                 |
| н                 | Examiner  |                  |   | 300   | o duv                            | 16                      | He                             | em                | eta<br>atc                 | me                       | 1                                   |                   | G.                                       | month                                 |
|                   |   | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury |   | a consequence                    | of):                    |                                |                   |                            |                          |                                     | 0                 | 2/1/2                                    |                                       |
| 1                 | be executed<br>sicien and<br>buriat-transit   | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last                                     | s   |                                  |                         |                                |                   |                            |                          | <u> </u>                            | يلاير             | & GZVORASA MOITASJA                      | W30                                   |
| Ö,                | e exe   |                  | resulting in death) cast  | Due to (or as   | a consequence                    | e of):                  |                                |                   | /                          |                          | $\mathcal{N}$                       | , -               | MairAsis.                                |                                       |
| 8760,             | ate b   | dicai            |   | d   |                                  |                         |                                |                   | -                          | Y                        | 9                                   |                   | OZHORONED -                              |                                       |
| 9                 | leath certifica<br>attending ph<br>i for use as th  | Me               | IF FEMALE:  | 12a Huga autooma  | -1                               |                         |                                |                   | _                          |                          | EXTENUES TO                         | MEDIC             | 9  |                                       |
| Вох               | ath cattend   | ian/             | 23b. Was decedent pregnant in the past 12 months?   | 3c. If yes, outcome<br>1☐Live birth                         | 2 Fetal deat                     |                         | Ectopic preg                   |                   |                            |                          | EXYMITE                             | 12.               | 23d. Date of deliment                    | very<br>Day Year                      |
| o.                | the de  | Physician/Med    | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown   | 4□ Pregnant at<br>9□ Unknown                                | time or death                    | 5                       | Other (spec                    | :my)              |                            |                          | 83N.                                |                   |  |                                       |
| ۵.                | res that the de<br>ligned by the a<br>be deteched t   | F.               | Part II. Other significant conditions cor   | ntributing to death be                                      | ut not resulting                 | in the un               | iderlying cau                  | se give           | n in Part I.               |                          | 23e. Dio                            | tobac             | co use contribute to                     | the cause of death?                   |
| ds                | uires<br>sign<br>Id be  | d by             |   |   |                                  |                         |                                |                   |                            |                          | 10                                  | ] Yes             | 2 No 3 □ Pro                             | bably 4 Unknown                       |
| 50                | w requir  | ete              |   |   |                                  |                         |                                |                   |                            |                          | 24a. Wa                             | is an             | 24h Were aut                             | opsy findings available               |
| of Vital Records, | e la<br>has   | Completed        |   |   |                                  |                         |                                | -                 |                            |                          | aut<br>per                          | opsy<br>formed    | prior to c<br>death?                     | ompletion of cause of                 |
| ta                | ician: Th<br>certificate<br>ector, pag  | 0                | 25. Was case referred to medical  |   |                                  |                         |                                |                   | 26 Place                   | of Death                 | 1 ☐ Yes                             | -/                | No 1 Yes                                 | 2 No                                  |
| <u> </u>          | Physician:<br>this certific<br>ral director.  | ToB              | examiner?<br>1 XYes 2 No  | fospital:   | ont 2□ER/O                       | utpatient               | 3 DOA                          | Othe              | -                          |                          | 19.                                 |                   | e 6 ther (Spec                           | My Hospica                            |
| 0                 | g Ph<br>er th   |                  | 27. Manner of Death   | 28a. Date of Injur  | ry 28b.                          | Time of<br>Injury       | 280                            | : Injury<br>Work  | at                         |                          |                                     |                   | njury occurred                           | 1104/100                              |
| Ö                 | Attending in death. ector: After by the fune  | atio             | 1 Natural 5 Pending 2 Accident investigation  | Cotober 21,   |                                  |                         | PM                             |                   | es 2 🔯                     | No                       | motor                               | ve                | hicle Acci                               | dent                                  |
| Division          | r Atte  | Certification:   | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Inju-<br>building, etc                        | ury - At home, f<br>c. (Specify) | farm, stre              | eet, factory,                  | office            | - CHI 441                  | 2                        | 8f. Location<br>City or T           | (Stree            | t and Number or Ru<br>tate)              | ral Route Number,                     |
|                   | ital o<br>irs aft<br>ret Di   |                  |   | FOADY   | MY                               |                         |                                |                   |                            |                          | I-95                                | uffe              | er freetold                              | ,NJ                                   |
|                   | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director. | edicai           | 29a. Certifier 1/1 Certifying Phy: (Check only 2 Medical Exami one)   | sician: To the best oner: On the basis of<br>and manner sta | f examination a                  | ge, death<br>ind/or inv | occurred at<br>restigation, in | the time<br>my op | e, date and<br>inion, deat | d place, a<br>th occurre | and due to the                      | e caus<br>e, date | e(s) and manner as<br>and place, and due | stated.<br>to the cause(s)            |
|                   | vithin<br>o the<br>omple  | Me               | 29b. Signature and title of certifier   | 1-  | <b>^</b>                         |                         |                                |                   | number                     |                          |                                     |                   | Date signed (Month                       |                                       |
|                   | - > - 0   |                  | I All Hith  | my the  | ly . V                           | an                      | 0                              | 25                | 520                        | 5                        |                                     | Jo                | 1913,<br>10. Md 2                        | 2006                                  |
|                   | 18  |                  | 30. Name and address of person who co   | omple ed cause of   | ea (Item 23a)                    | ) (Type, I              | Print)                         | - 1               |                            | r .                      | 0                                   | 0                 |  |                                       |
| _                 | 10  |                  | W. A. Rilay   | 631   | 1c 6                             | 701                     | N-0                            | Ch                | nle                        | 77                       | 150                                 | Ut                | o. Md <                                  | 12030                                 |
|                   | Sta   |                  | 31. Date filed (Month, Day, Year)   |   | ar's Signature                   | And                     | Marke J                        |                   |                            |                          |                                     |                   |  |                                       |
|                   | Regist  | ai               | .IIII 2 I ZUU   | U MEET PERIOR   | 1 15                             | 1965                    | 1                              |                   |                            |                          |                                     |                   |  |                                       |

|              |   |                     | 1 - For<br>Stata<br>Registrar   | State of Maryland   | / Department of Health  Certificate of Death   | h  | iene 2006 22847  |
|--------------|---|---------------------|---|---|--|--|--|
| E            | Physici<br>/Medic   |                     | Decedent's Name (First, Middle, Last  | "Sarah  | Biancucc   | 2. Date of Deal Month                                  | Day 2006 7:04 AM   |
|              | Examin<br>Funeral<br>Director   | 4.                  | 4a. Facility Name (If not institution, give  5. Social Security Number  6. S  1  Usual Residence of Decedent  | Nursing Ct  | 4b. City, Town, or Location  A thirthday)  Yrs.  4b. City, Town, or Location  A thirthday)  If Under 1 Year  Months Days Hours | or 24 Hrs. 8. Date of Birth<br>Min. Month, Day,        | 4c. County of Death  N/A  9. Birthplace (State or Foreign Country)  9, 1918 Illinois |
|              | aryland<br>ahow   | 7                   | 10a. State 10b. County MD N/A   |   | Town or Location Ltimore City  |  | 10d. Inside City Limits 11☑ Yes 2 □ No   |
|              | ith the M<br>or 28e-1   | Olrecto             | 10e. Street and Number  |   | 10f. Zip Code  | 1  | 0g. Citizen of What Country?   |
| 036          | 72 hours after death with the Maryland<br>"natural", or Itama 23a or 28e-f ahow<br>scioal Evanting must be modified at  | by Funeral Director | 3220 Benson Aver  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | 1UC  12. Was Decedent Ever in U.S Armed Forces?  1  Yes 2 X No If Yes, Give Year or Dates:    | . 13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 1 ☐ Yes 2 ☒ No Specify  | Origin? (Specify Yes or No-<br>an, Puerto Rican, etc.) | United States  14. Race - American Indian, Black, White, etc.  Specify: White        |
| 121          | within  | Completed           | 15. Decedent's E. (Specify only highest gra   | ucation<br>de completed)<br>College (1-4or 5+)  | 16a. Decedent's Usual Occupation (Give kind of work done during mo-<br>life. DO NOT use retired)  Homemaker                    | ost of working   | 16b. Kind of Business/Industry Own Home  |
| 73           | should be filed with<br>nd Mental Hygiene<br>marked other tha<br>matic avant, Ins.  | To Be Co            | 8<br>17. Father's Name (First, Middle, Last,<br>Dominic Messina   |   | 18. Mot  | her's Name (First, Middle, I                           |  |
| Mary         | 12 should be f<br>h and Mental H<br>7 Is marked of<br>reumstic ava  |                     | 19a. Informant's Name/Relationship (  | 1   | 19b. Mailing Address (Street and Numi  |  | 20.0   |
| Baltimore, N | 0 0 = 5   | 1                   | Mary Jane Thomas  20a. Method of Disposition  1\times \infty \infty \text{Burial} 2 \process{Cremation} 3 \process{Cremation}  4 \process{Donation} 5 \process{Other (Special)} | Removal from State 20b. Pla   | 7503 Munroe Circle use of Disposition (Name of metery, crematory or other place)   | Date   | arnie, MD 21061<br>20c. Location - City or Town, State<br>Baltimore, Maryland        |
| Baltir       | permit. Pag<br>Department<br>Important: I<br>any injury o   |                     | 21. Signature of Funeral Service Licer  | ISEE LA TAL   | wood Cemetery  22. Name and Address of Fac  Gary L. Kaufmar  7250 Washington   | n Funeral Hon  | ne @ MMP, Inc.   |
|              | Physician<br>/Medical<br>Examiner   |                     | 23a. Part1. Enterthe disease, or com<br>shock, or beart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)                             | a. Due to (or as a conseque   |  | as cardiac or respiratory arr                          | est, PID 41 Approximate Interval Between Onset and Death                             |
| 8760,        |   | cal Examiner        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                      | Due to (or as a conseque  | onary arter  | y disea  | se years   |
| O. Box 6     | Physician: The taw requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown   | 23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of deal 9 Unknown | death 3 Ectopic pregnancy  |  | 23d. Date of delivery<br>Month Day Year  |
| rds, P       | w requires that<br>been signed b<br>should be deta  | ρ                   | Partle Other significant conditions of RNEUMOTON  | ontributing to death but not result   | ting in the underlying cause given in Part   | t I. 23e. Did to                                       | bacco use contribute to the cause of death? es 2 No 3 Probably 4 Minknown            |
| Il Records,  | The law requisate has been page 2 should  | Completed           |   |   |  | 24a. Was a autops perford                              | sy prior to completion of cause of   |
| Vital        | sician: The<br>certificate<br>rector, pag   | Be                  | 25. Was case referred to medicat examiner?  1 Yes 2 No  | Hospital: 1 ☐ Inpatient 2 ☐ E   | Other  | ce of Death (Check only or                             |  |
| of           | g Physical disperal di  | n: To               | 27. Manner of Death   |   | 28b. Time of linjury at Work?  | Qursing Home 5 Reside                                  | ow injury occurred   |
| Division     | To the Hosyttet or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page                          | Certification:      | 1. Matural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined  | 9 380 Blood of Jojuny - At hos  | M 1 ☐ Yes 2 ☐ ne, farm, street, factory, office  |  | treet and Number or Rural Route Number,<br>n, State)                                 |
|              | ne Hospitte<br>n 24 hours<br>ne Funerel<br>netely filled  | Medical C           |   |   | rledge, death occurred at the time, date a on and/or investigation, in my opinion, de  |  |  |
|              | To th<br>withir<br>To th<br>comp  | Me                  | 29b. Signature and title of certifier   | ny/m  | 29c. License number  | 391  | Tulvi8, 2006   |
| . 0          | Str   | ate                 | O. Name and address of person who  31. Date filed (Manth, Day, Year)  | com, letted cause of death (Item :  | anne, baltim   | ore, Mar   | yland 21227  |

SARAH

BIANCURCI

|             |   |                   | For<br>State<br>Registrar   | State of Ma  | aryland / Dep<br><i>Ce</i>                               | artment of H<br>rtificate of                                 |  | P                                     | Reg. No UU6                                     | 22848  |
|-------------|---|-------------------|---|--|--|--|--|---------------------------------------|---|--|
|             | Dhinaiai  |                   | 1. Decedent's Name (First, Middle, Last   | )  |  |  |  | 2. Date of Dea<br>Month               | ith<br>Day Year                                 | 3. Time of Death                                 |
|             | Physicia<br>/Medic  | al                | Helen Nora  |  |  | T  |  | July 18                               |   | 3:00 P M   |
|             | Examin  | er                | 4a. Fecility Name (If not institution, give   | street and number)   |  |  | r Location of Deat                       | h                                     | 4c. County of Dea                               |  |
|             |   |                   | 2503 Putnam Road 5. Social Security Number 6. Se  | 7.00   | e (In yrs. last birthday,                                | Forest If Under 1 Year                                       | Hill<br>If Under 24 Hrs                  | 8. Date of Birth                      | Harford   |  |
|             | Funeral<br>Director   |                   | ,   | x  | 81 Yrs.  | Months Days  | Hours Min.                               |                                       |   | thplace (State or Foreign<br>ountry)<br>rginia   |
|             | fand<br>ow  |                   | 10a. State 10b. County  |  | 10c. City, Town or L                                     | ocation  |  |                                       |   | 10d. Inside City Limits                          |
|             | Mary<br>I ah  | tor               | Maryland Harford  |  | Forest Hi  | 11   |  |                                       |   | 1 ☐ Yes 21☑ No                                   |
|             | 72 hours after death with the Maryland<br>natural', or Items 23e or 28e-f ahow<br>Jigal Examinat must be notified at      | Director          | 10e. Street and Number  |  | 101000 111   | 10f. Zip Code  | -  |                                       | 10g. Citizen of What C                          | ountry?  |
|             | th wit  | aiD               | 2503 Putnam Road  | l  |  | 21050  |  |                                       | USA   |  |
|             | ems<br>erm  | Funerai           | 11. Marital Status  | 12. Was Decedent<br>Armed Forces?                                      | Ever in U.S. 13.   | Was Decedent of H  | lispanic Origin? (S<br>an, Mexican, Puer | Specify Yes or No-<br>to Rican, etc.) | 14. Race - Am<br>Black, Whi                     |  |
| 98          | or it   |                   | 1 Never Married 2 Married   | 1 ☐ Yes 2 ☐ ☐  |  | 1 ☐ Yes 2 ☐ No   | Specify:                                 |                                       | Specify:  |  |
| 8           | ural',  | d by              | 3 Widowed 4 □ Divorced  | Year or Dates:   | 150 Door   | 26   | nation                                   |                                       | 16b. Kind of Business                           | White  |
| 21215-0036  |   | Completed         | 15. Decedent's Ed<br>(Specify only highest grad   | de completed)  | (Give  | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | during most of wo                        | rking                                 | TOD. KING OF BUSINESS                           | amuustry   |
| 12          | within<br>iene.<br>than   | mo                | Elementary/Secondary (0-12)   | College (1-4or 5   |  | maker  | ,  |                                       | Own Home  |  |
| 0           | Hygiv<br>other<br>ent, I  | Be C              | 17. Father's Name (First, Middle, Last)   |  | Home   | TICOTOL  | 18. Mother's Na                          | me (First, Middle,                    | Maiden Sumame)                                  |  |
| <u>la</u> n | should be filed withir<br>ind Mental Hygiene.<br>s marked other than<br>umatic event, Ita M                               | o B               | Hayes (nmn) Ha  | rris   |  |  | Nora                                     | (nmn) Mo                              | :Fadden   |  |
| Maryland    | w   | -                 | 19a. Informant's Name/Relationship (7   | ype, Print)  | 19b. Mail  | ng Address (Street   | and Number or R                          | u <i>ral R</i> oute Num <i>b</i> e    | r, City or Town, State,                         | Zip Code)  |
|             | 1 and 2<br>Health a<br>tem 27 Is  |                   | Ruth Troy / Daugh   | ter  |  |  |  | rest Hill                             | , MD 21050                                      |  |
| Baltimore,  | of Hea<br>of Hea<br>fitem<br>r other  |                   | 20a. Method of Disposition 1   Surial 2 □ Cremation 3 □   | Domoval from State   | 20b. Place of Disp<br>cemetery, cre                      | osition (Name of<br>matory or other pla                      | сө)                                      | Date                                  | 20c. Location - City of                         | Town, State                                      |
| Ĕ           | Pages<br>nent of I<br>ant: If its<br>ury or o   |                   | '4 □Donation 5 □ Other (Specify   |  | Bel Air  | Memorial   | Grdn. 7                                  | -21-06                                | Bel Air, N                                      | aryland  |
| alt         | permit. Pag<br>Department<br>Important: I<br>any injury o   |                   | 21. Signature of Funeral Service Licen:   | S88  |  | 2. Name and Addre  |  |                                       |   | -  |
| <b>B</b>    | 90 F # 9  |                   | 23a. Part1. Enter the disease, or comp  | male   |  | 1317 Coke  | esbury Ro                                | oad, Abir                             | ngdon, Mary                                     | land 21009                                       |
| 8760,       | hysician and hysician and sthe burial-transit   | ical Examiner     | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as   | a consequence of): a consequence of): a consequence of): | And row  |  |                                       |   |  |
| .O. Box 6   | t the death certif<br>by the attending<br>ached for use a   | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown   | 23c. If yes, outcome<br>1 □Live birth<br>4 □ Pregnant a<br>9 □ Unknown | 2 Fetal death 3  | ⊒Ectopic pregnanc<br>⊒ Other (specify) _                     | у  |                                       | 23d. Date of de<br>Month                        | elivery<br>Day Year                              |
| ecords, P.  | quires tha<br>n signed l<br>uld be det  | b                 | Part II. Other significant conditions of  | ontributing to death b   | out not resulting in the                                 | underlying cause gr  | ven in Part I.                           |                                       | obacco use contribute t<br>′es 2 □ No 3 □ P     | o the cause of death?<br>robably 4  Unknown      |
| $\propto$   | sician: The law requir<br>s certificate has been si<br>lirector, page 2 should I  | Completed         |   |  |  |  |  | 24a. Was autop<br>perfor<br>1 Yes     | sy prior to                                     | utopsy findings available completion of cause of |
| Vital       |   | Be C              | 25. Was case referred to medical  |  |  |  | 26. Place of De                          | ath (Check only or                    |   |  |
| >           | Physician:<br>this certific<br>ral director,  | ToE               | examiner? 1 Yes 2 No  | Hospital: 1 ☐ Inpati   | ent 2 ER/Outpatie  | nt 3 DOA   |  | Home 5∑ Resid                         | lence 6 ☐Other (Spe                             | ecify)   |
| n of        | - he -  |                   | 27. Manner of Death 1 12 Natural 5 ☐ Pending  | 28a. Date of Inju<br>(Month, Da  | ury 28b. Time (  | Wo   | ry at<br>rk?                             | 28d. Describe h                       | now injury occurred                             |  |
| <u>.</u>    | death.<br>ctor: Ai<br>y the fu  | catio             | 2 Accident investigation  |  |  | M 1  | Yes 2□No                                 |                                       |   |  |
| Division    | ter de lirect   | Certification:    | 3 Suicide 6 Could not be<br>4 Homicide determined   | 289. Place of III  | jury - At home, farm, s<br>tc. <i>(Specify)</i>          | treet, factory, office                                       |  | 28f. Location (S<br>City or Tow       | Street and Number or F<br>vn, State)            | lural Route Number,                              |
| ٥           | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune |                   | (Check only 2 Medical Exam  | niner: On the basis of   | of examination and/or i                                  |  |  |                                       | cause(s) and manner a<br>date and place, and du |  |
|             | the I   | Medicai           | one)  | and manner st  | ated.  | 29c. Licen   | se number                                |                                       | 29d. Date signed (Mor                           | th. Day. Year)                                   |
|             | on Con  | -                 | 29b. Signature and title of certifier.  | mis M  |  | 250. 2001  | 1521                                     |                                       | 7.20-6  |  |
|             | 5   |                   | 30. Name and address of person who  | 0 110  | School (Type   | Pynt) Hen  | 1 vally                                  | M) 2                                  | 1030  |  |
|             | Sta<br>Regist   | ate<br>rar        | 31. Date filed (Month, Day, Year)  JUL 2 1 2006   |  | rar's Signature  | de   |  |                                       |   |  |

|              |  |                   | 1- For State of Maryland / De Registrar  | partment of<br>ertificate of   |                                     | ind Mental F  | lygiene                     | 106 2284   |
|--------------|--|-------------------|--|--|-------------------------------------|---|-----------------------------|--|
|              | Physic<br>/Medi  | cal               | 1. Decedent's Name (First, Middle, Last)  MARJORLE J. BOGUS  |  |                                     | 2. Date of Month                                      | 8 348 429                   | Year 3. Time of Death  |
| e)           | Exami  | ner               | 4a. Facility Name (If not institution, give street and number)  5. Social Security Number  6. Sex  7. Age (In yrs. last birthda)   | 4b City Town,  | T If Under 2                        | ENE   |                             | y of Death  A  9. Birthplace (State or Foreign                                       |
|              | Director   |                   | 213-40-0054  |  | Hours                               | Feb. 2  | Birth (Day, Year) (6, 1941) | Maryland   |
|              | r 28a-f eho  | Director          | Maryland Baltimore Baldwi  |  |                                     |   | 10g. Citizen of \           | 10d. Inside City Limits 1 Yes 2 No   |
| 0036         | be filed within 72 hours after death with the Maryland and Hygiene. All Hygiene. Ad thygiene. Ad other than "naturel", or items 23s or 28s-f show event, I'm Medical Exacid with reast be notified at  | by Funeral        | 3 Widowed 4 Divorced If Yes, Give Year or Dates:   | 2101 3. Was Decedent of If Yes, specify Cub  | Hispanic Origoan, Mexican, Specify: | in? (Specify Yes or<br>Puerto Rican, etc.)            | U.                          | S.A.<br>e- American Indian,<br>ck, White, etc.                                       |
| 121215-      | e filed within 72 l<br>il Hygiene.<br>other than "nat<br>vent, It e Medic  | Completed         | Elementary/Secondary (0·12)  College (1-4or 5+)  Cust  | cedent's Usual Occu<br>ive kind of work done<br>a. DO NOT use retire<br>tomer Serv | during most<br>vice Re              | р.  | Gas C                       | usiness/Industry   |
| arylanc      | s should be fi<br>and Mental H<br>is marked of<br>sumatic ever   | To Be             | 17. Father's Name (First, Middle, Last)  Henry Edward Mancini  19a. Informant's Name/Relationship (Type, Print)  19b. Ma   | tiling Address (Street   |                                     | 's Name (First, Midd<br>Harriet<br>or Rural Route Num | t Sul                       | llivan   |
| e)<br>Z      | 1 end 3<br>Health<br>tem 27<br>other tr  |                   | Stephen R. Bogusky, Sr. Husband 136  20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery, cr  | 509 Devonb<br>position (Name of<br>rematory or other pla                           | rook R                              | oad Bald  | win, Mary<br>20c. Location  | City or Town, State  |
| <b>Balti</b> | permit. Peges Department of Important: If it eny Injury or o   |                   | 21. Sinal te official Service Licensee   | Cemetery 22. Name and Addre 1050 York  | ess of Facility<br>Road             | Towson,   | Maryland                    | Maryland<br>Tal Home, Inc.<br>I 21204  |
| y            | Physician be executed by Medical Examiner transit to private the private transit to the private transit to the private transit to the private transit to the private transit to the private transit tr | dical Examiner    | 23a. Part1. Enter the disease, or comblications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of): | nter the mode of dyii  | ng, such as c                       | ardiac or respiratory                                 | arrest,                     | Approximate Interval Between Onset and Death   |
| P.O. Box 687 | ettending<br>for use as  | Physician/Me      |  | □Ectopic pregnancy   |                                     |   | Mon                         |  |
| Records,     | aw requires inet ine de<br>is been signed by the<br>2 should be detached   | Completed by      | ASPIVATION PNEUMONIA   | underlying cause giv   | ven in Part I.                      |   | Yes 2□No                    | ibute to the cause of death?  3 Probably 4 Ninknown  Vere autopsy findings available |
|              |  | Be Com            | 25. Was case referred to medical examiner?   |  | 26. Place o                         | auto  | opsy proformed? de 2024 1   | rior to completion of cause of eath?   |
| vision of    | Attending Priya  | Certification; To | 1   Yes   2   No   | of 28c. Injun<br>World<br>M 1  | 4 LI NUIS                           |   | how injury occurre          |  |
|              | Funere<br>Funere   | Medicai Cert      | 29a. Certifier  (Chack on)  29 Medical Examiner: On the basis of examination and/or in   | ith occurred at the tin  | ne, date and p                      | City or 10  | own, State)                 |  |
| )            | within 2   | Mec               | 29b. Signature and title of certifier  | 29c License  |                                     | 34  |                             | (Month, Day, Year)   |
| _/           | 5  |                   | 30. Name and address of person who completed cause of death (Item 23a) (Type   | i, Pri t)  | PLA                                 | E BA  | 2D 12021                    | E 1051505  |
|              | Sta<br>Registra  |                   | 31. Date filed (Month, Day, Year)  32. Registrar's Signature   | book   |                                     |   |                             |  |

|                |  | 1                             | For State Registrar  | State of Maryl   | -                              | artment of<br>rtificate of                                  |  | Reg  | g. No. 2 0 0 6   | 22850  |
|----------------|--|-------------------------------|--|--|--------------------------------|---|--|--|--|--|
|                | Physicia<br>/Medic   | in<br>al                      | Donald Ellsw     Ame (If not institution, give   | orth Bosley  |                                | 4h City Town  | or Location of Death                         | 2. Date of Death<br>Month<br>July                  | Day Year<br>19 2006<br>4c. County of Deat                      | 3. Time of Death                                 |
|                | Examin<br>Funeral  | Ç1                            | Carroll Hospital  5. Social Security Number 6. So  | Center 7. Age (In)   | rrs. last birthday,            | Wes   | stminster                                    | 8. Date of Birth<br>Month, Day 1                   | Carroll  | hplace (State or Foreign<br>unity)<br>TYLand     |
| 100            | Director   |                               | Usual Residence of Decedent  10a. State  10b. County   |  | . City, Town or L              | ocation   |  | raren aj   | 1932 Fia   | 10d. Inside City Limits                          |
|                | with the Maryl<br>or 28a-f sho   | Director                      | Maryland Carroll  10e. Street and Number  3724 Millers Sta   | tion Pd  | Manch                          | 10f. Zip Code   |  | 100  | g. Citizen of What Co  | 1 □ Yes 2 ፟ No<br>untry?                         |
| 36             | int. Pages 1 and 2 should be filed within 72 hours after death with the Maryland saftment of Health and Mental Hygiene.  artment of Health and Mental Hygiene.  fordant: If team 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, if a Medical Examinar must be notified at injury or other traumatic event, if a Medical Examinar must be notified at the second control of the sec | Completed by Funeral Director | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | 12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:          | in U.S. 13.                    |   | Hispanic Origin? (Sp<br>ban, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)                   | 14. Race - Ame<br>Black, White<br>Specify White                | e, etc.  |
| 21215-0036     | I within 72 hou<br>iene.<br>r than "natura<br>the Medical E  | ompieted                      | 15. Decedent's Ec<br>(Specify only highest gra<br>Elementary/Secondary (0-12)  | ucation<br>de completed)<br>College (1-4or 5+)   | (Give                          | edent's Usual Occ<br>e kind of work don<br>DO NOT use retii | e during most of work<br>red)                | ing 10   | 6b. Kind of Business/  | Industry   |
| Maryland 2     | ould be filed<br>Mental Hyg<br>karkad other<br>katic event,  | To Be C                       | 17. Father's Name (First, Middle, Last)  Leroy Ellswor   | th Bosley  |                                |   | Mabe:  | e (First, Middle, Ma<br>L Emma Tr                  | racey  | Tip Code   |
| re, Mar        | is 1 and 2 shot that the site of the straum.   | 1                             | 19a. Informant's Name/Relationship ( Doris Bosley - W:  20a. Method of Disposition   | ife 20   | 3724                           |   | Station Re                                   | d. Manche  | City or Town, State, 2<br>ester, Md.<br>Oc. Location - City or | 21102  |
| Baltimore,     | permit. Pages 1 and<br>Department of Health<br>Important: If Item 27<br>any injury or other tr<br>ance.  |                               | 1 🖺 Burial 2 Cremation 3 C 4 Donation 5 Other (Specification 21. Signature of Juneral Service Licer  | )  |                                |   | July 22,2<br>Tenservi Ci<br>Trail Dr. Ma     |  | Hampstead, Md. 2110  |  |
| 760,           | Physician /Medical Examiner  pe penual-fransil   | icai Examiner                 | shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as a cor b. Due to (or as a cor c. Due to (or as a cor d.                  | nsequence of):                 | lang  | organ<br>jihis                               | Fair   | luxe   | Onset and Death  Delay                           |
| .O. Box 68     | The law requires that the death certifica<br>Ne has been signed by the attending phoage 2 should be detached for use as it   | Physician/Med                 | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome of pro<br>1 □ Live birth 2 □<br>4 □ Pregnant at time<br>9 □ Unknown | Fetal death 3                  | □Ectopic pregnar  |  |  | 23d. Date of del<br>Month                                      | ivery<br>Day Year                                |
| <b>Q</b>       | w requires that<br>been signed by<br>should be deta  | 2                             | Part II. Other significant conditions of   | ontributing to death but no  | t resulting in the             | underlying cause  | given in Part I.                             | 23e. Did toba                                      | acco use contribute to   | o the cause of death?                            |
| Vital Records, |  | Completed                     |  |  |                                |   |  | 24a. Was an autopsy perform                        | prior to death? No 1 □ Yes                                     | utopsy findings available completion of cause of |
| o              | ding Phys<br>n.<br>After this<br>funeral di  | ation: To Be                  | 25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation   | 28a. Date of Injury<br>(Month, Day Yea   | 2 ER/Outpatie 28b. Time Injury | of 28c. In  | Other: 4 Nursing He                          | th (Check only one ome 5 Resider 28d. Describe how | nce 6 Other (Spe   | city)  |
| Division       | Hospital or Atteni<br>24 hours after deatl<br>Funeral Director:<br>tely filled in by the   | Medical Certification:        | 3 Suicide 6 Could not be determined  | building, etc. (S)   |                                |   |  | City or Town,                                      |  |  |
|                | To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by   | Medica                        |  | nysician: To the best of my<br>niner: On the basis of exa<br>and manner stated.          |                                | investigation, in m   |  | rred at the time, da                               |  | o to the cause(s)                                |
| •              |  |                               | 30. Nami and address of person who   | completed cause of death   | (Item 23a) (Type               | D 4   | 4614   |  | July 20  | , 2006   |
|                | St   | ate                           | 31. Date filed (Month, Day, Year)  | 32. Registrar's S  |                                | stun  | uster 1                                      | MD   | 2115   | )  |
|                | Regist   | rar                           | JUL 2 1  | 2006 Store   | U D.                           | Spark   |  |  |  |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Deeth Month Duy **Physician** 2006 JULY /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner Sykesville Carroll **Brintonwoods Nursing Home** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2X F Months Director 76 214.28.9220 April 5, 1930 Maryland Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Marylend nent of Health end Mental Hygiene. 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location or 28a-f show 1 ☐ Yes 2 No Director Sykesville Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a 21784 7426 Village Road; Apt. 111 U.S.A Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No 11. Maritel Status Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🗷 No Specify Yes Give Specify. White 3-N Widowed 4 □ Divorced Year or Dates 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 11 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Depertment of Health end Mental Important: If item 27 is marked of any Injury or other traumatic eve P Walter B. Williams, Sr Mary Irene Caricoff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 339 Kingston Circle Sykesville, Maryland 21784 Mr. Walter Bowie 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/15/2006 Bridgewater, Virginia Oak Lawn Cemetery 22. Name and Address of Facility Sonature of Funeral Service Licenses Slack Funeral Home, P.A. 111005 30 3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Schemic Cardida Examiner Examiner for use as the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Yes 2 70 1 ☐ Yes 2 € NO director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner<sup>4</sup> Other: 4 2 ursing Home 5 Residence 6 Other (Specify) Hospital: edical Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28d. Describe how injury occurred 27. Menner of Death 28c. Injury et Work? After 1 [UNatural 5 Pending investigation 1 Tes 2 🗆 No within 24 hours efter deeth. To the Funersi Director: A 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 A critifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted. 29a. Certifie completely To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certific eddress of person who completed cause of death (Item 23e) (Type, Print) weres 1000 CK 31. Date filed (Month, Day, Year) Registrer's Signature State JUL 2 0 2006 Registrar

#### 06-05079 Conner Brown

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

| onner brown  | 1- For State Control of Certificate of Death   | Reg N                                      | 10. 2006  | 2285   |
|--|--|--|---|--|
| Physician/   | Registrar  1. Decedent's Name (First, Middle,Last)   | 2 Date of Death<br>Month Da                | y Year  | Time of Death<br>1420 hrs                          |
| Medical Examiner   | Conner Edward Brown 4a Facility Name (if not institution, give street and number) 4b. City. Town, or Location  | July 15, 2006<br>of Death                  | 4c. County of Death                                 | 1420 1115  |
|  | St. Mary's Hospital ER  Leonardtown  |  | St. Mary's  |  |
| Funeral<br>Director  | 215-69-6509 1XM 2F 2 Yrs. Months Days Hour   | ,  | M/DD/YYYY) 9. Birthpl<br>Foreign<br>Counti          |  |
| nd<br>show any<br>ice.   | Usual Residence of Decedent  10a State 10b County 10c. City, Town or Location Elli   | cott City                                  | 1   | id. Inside City Limits  Yes 2 X No                 |
| in the Maryland 23a or 28a-f show notified at once.  |  | 042  | Citizen of What Country                             |  |
| er death wi<br>or items<br>r must be<br>Funera   | 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year  12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 X No 1 Yes, Specify Cuban, Mexical 1 Yes, Specify Cuban, Mexical 1 Yes, Specify Cuban, Mexical   | n, Puerto Rican, etc.)                     | 14. Race - Americar<br>White, etc.<br>W<br>Specify: | hite   |
| ours afte autural" xaming  | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give during most of working life. DO NO   |  | o. Kind of Business/Indu                            | ıstry  |
| 5-0036 ed within 72 hour lygiene other than "natu the Medical Exan Completed   | Elementary/Secondary (0-12) College (1-4 or 5+)  Never worked  |  |   | worked   |
| 215-(<br>be filed out<br>the oth<br>ent, the   | Donald Edward Brown  |  | aith Moo  | re   |
| y, MD 21215-0036 and 2 should be filed within 72 teath and Mental Hygiene tem 27 is marked other than traumatic event, the Medical To Be Comple  | 19a. Informant's Name/Relationship (Type, Print)  Mr. Donald Brown father 13301 Triadelph  |  |   |  |
| Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Neutal Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Comple  | 20a. Method of Disposition  1 Burial 2XX Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  A 1 1 County Cremato  | 7 / 1 9 / 0 6                              | oc Location - City or To                            | wn, State  |
| Baltimore permit Pages   Department of P Important: If injury or other   | 2) Signature of Funcies Service Licenses 22. Name and Address of Facility Service Licenses 22. Name and Address of Facility Service Licenses 23. Name and Address of Facility Service Licenses 24. Name and Address of Facility Service Licenses 25. Name and Address of Facility Service 25. Name and Address of Facility Service 25. Name and Address of Facility Service 25. Name and Address of Facility Service 25. Name and Address of Service 25. Name and Address of Service 25. Name and Address of Ser | *3871 Old Co                               | olumbia P   | ike 2104   |
| Physician<br>/Medical<br>Examiner  | 23a Part I. Enter No. 1 Pease, or complication that caused the death. Do not enter the mode of dying, such as failure. List only one cause on each line.  Immediate Cause (Final disease a. Su ravalcular aortic stenosis  | cardiac or respiratory arrest,             | shock, or heart                                     | Approximate Interval<br>Between Onset and<br>Death |
| , and the second   | or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.  |  |   |  |
| aminer   | If any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):   |  |   |  |
| 68760, certificate be executed nding physician and se as the bural-transit   | d  | c m  |   |  |
| 760, icate be ex physician the burial.   | IF FEMALE: 23c. If yes, outcome of pregnancy   |  | 23d. Date of delivery                               |  |
| b. Box 687 the death certification of the attending pools of the control of the c | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ector 4 Pregnant at time of death 5 Other (Specify) 9 Unknown  | oic pregnancy                              | <b>M</b> onth Day                                   | Year   |
| P.O. B es that the d   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F   |  | co use contribute to the                            |  |
| Division of Vital Records, P.O. Box 68 ral or Attending Physician: The law requires that the death certifical price of the this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as certification. To Be Completed by Physician  |  | 24a. Was an autopsy performe               | prior to com<br>d? death?                           | ssy findings available apletion of cause of        |
| nn: Th   | Ed. 17dd ddd fefall d to file alda.  | h (Check only one)                         |   |  |
| F Vita   | examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other,4   |  | sidence 6 Other:                                    |  |
| n of   | 27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day,Year)  28b. Time of Injury 28c. Injury at Wo   | _  | injury occurred                                     |  |
| Division of Vital Recspiral or Attending Physician: The Incurs after death meral Director: After this certificate I filled in by the funeral director, page  | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)   | etc. 28f. Location (Stre<br>or Town, State | et and Number or Rural                              | Route Number, City                                 |
| Spi Pin C  | (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and processing the control of the best of my knowledge, death occurred at the time, date and processing the control of the best of my knowledge, death occurred at the time, date and processing the control of the best of my knowledge, death occurred at the time, date and processing the control of the best of my knowledge, death occurred at the time, date and processing the control of the best of my knowledge, death occurred at the time, date and processing the control of the best of my knowledge, death occurred at the time, date and processing the control of the best of my knowledge, death occurred at the time, date and processing the control of the best of my knowledge, death occurred at the time, date and processing the control of the best of my knowledge, death occurred at the time, date and processing the control of the best of the best of my knowledge, death occurred at the time, date and processing the control of the best of the best of the best of time and the best of | place, and due to the cause(s              | ) and manner as started                             | l.<br>:ause(s)                                     |
| To the Ho within 24 To the Fu completely   | one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.  29b. Signature and title of certifier 29c. License number  |  | 9d. Date signed (Month                              |  |
|  | Theorem I Day The un to O.C.M.E.   | J  | luly 16, 2006                                       |  |
|  | Theodore III Tang  | altimore, MD 21201                         |   |  |
| Stat<br>Registra   | The state of the s |  |   |  |

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Carson Dale Cross July 2006 06:30\_a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1₽M 2□F 233-44-5159 74 April 9, 1932 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits r 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r then "natural", or Items 23a or the Medical Examiner must be 1633 Tieman Drive 21061 U.S.A. death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
ant: If Item 27 is marked other ther
ury or other traumatic event, traum Crane Operator Craneman Rigger 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Eugene Cross Beulah Marie Kerns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Ida Mae Cross 1633 Tieman Drive Glen Burnie MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Depertment of the Important: If Its
ony injury or of and injury or of and injury or of and and injury or of and 1 Burial 2XX Cremation 3 Removal from State West Arundel Crematory 7-24-2006 Identon Maryland 4 ☐ Ponation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21. Signature of Funeral Service Licens 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Diabetes Physician inkrown /Medical Due to (or as a consequence of): Examiner Hypertension unknown Sequentially list conditions, and leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by s been signe should be c 1 Yes 2 No 3 Probably 4 Munknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificete 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 \( \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) ဥ 1 Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 ☐ Pending ours efter death. neral Director: Af filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide ö 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical To the Hosp within 24 ho To the Fune completaly f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Chairman, ER DO04162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year)
JUL 2 1 2006 State Registrar

Please Type or Print in Black Indelible Ink

| olin R. Cramer  | 1               | State of Maryland   | Department // Department // // // // // // // // // // // // // | of Health and Mental H of Death  |  | 200   | 6 2285                     |  |  |  |
|---|-----------------|---|---|--|--|---|----------------------------|--|--|--|
| Physicia  | n/              | Registrar   Colinary   Cramor   Month Day Year   Month Day Year   Cramor   Colinary   Cramor   Month Day Year   Cramor  |   |  |  |   |                            |  |  |  |
| ledical Examir  |                 | 4a. Facility Name (if not institution, give street and number)  | July 19, 20   | 4c. County of Death  | 1333 hrs   |   |                            |  |  |  |
| -   |                 | Johns Hopkins Bayview Medical Center  | Baltimore   |  |  |   |                            |  |  |  |
| Funeral<br>Director   |                 |   | e (In yrs. last birthday)                                       | Months Days Hours Mir  | <del>,                                    </del> | h(MM/DD/YYYY) 9. Birt<br>Foreig                 | n                          |  |  |  |
| Bircotor  | +               | 217 62 7006 1XM 2 F Usual Residence of Decedent   | 46  | Yrs.   | Aug. 2   | 20,1959 Co                                      | untry)Maryland             |  |  |  |
| w any   | Ī               | 10a State 10b. County 10c. City, Town or Location   |   |  |  |   |                            |  |  |  |
| Aaryland<br>28a-f show<br>1 at once.  | ţţ.             | Maryland Baltimore  10e. Street and Number  | Esse  | X 10f. Zip Code  | 10   | ng. Citizen of What Cour                        | 1 Yes 2 X No               |  |  |  |
| the Ma<br>a or 28<br>tified a   | Director        | 809 Martin Road   |   | 21221  |  | USA   | 1                          |  |  |  |
| th with<br>ems 23<br>at be no   | Funeral         | 11. Marital Status  1 Never Married  2 X Married  12. Was Decedent Armed Forces   | >   | Was Decedent of Hispanic Origin? ( S<br>If Yes, specify Cuban, Mexican, Puerto |  | 14. Race - Ameri<br>White, etc.                 | can Indian, 8lack,         |  |  |  |
| fter dea  | - 1             | 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year  | X No  | Yes 2 X No specify:  |  | Specify Whi                                     | nite                       |  |  |  |
| hours a   | ed by           | 15. Decedent's Education (Specify only highest grade cor<br>Elementary/Secondary (0-12) College (1-4 or   | during  | dent's Usual Occupation (Give kind of<br>g most of working life. DO NOT use re |  | 16b Kind of Business/I                          | ndustry                    |  |  |  |
| 136<br>thin 72<br>ne.<br>than "   | ompleted        | 12  |   | e Repairman  |  | Marine  | Terminal                   |  |  |  |
| Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once   | O               | 17. Father's Name (First, Middle, Last)  (unknown)  |   | 18.Mother's Nam<br>Glad  | e (First, Middle, N                              | Maiden Surname)  Cramer                         |                            |  |  |  |
| 2121<br>wild be 1<br>Mental<br>marke<br>c event   | o Be            | 19a. Informant's Name/Relationship (Type, Print )   |   | illing Address (Street and Number or   | Rural Route Num                                  | nber, City or Town, State                       | Zip Code)                  |  |  |  |
| MD d 2 sho lth and n 27 is aumati   |                 | Sharon Cramer (wife)  |   | Martin Road Esse   |  | and 21221<br>20c. Location - City or            | Town State                 |  |  |  |
| ore,<br>ges l ar<br>t of Hee<br>ther tr   |                 | 20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from St  | ate crematory o   | r other place)   | ıl <sup>Date</sup> 24,<br>2006                   |   | County, Md                 |  |  |  |
| Baltimore, Department of He Important: If ite   |                 | Donation 5 Other Specify: 2 Signature of Fineral Sprice Licensee  |   | 2. Name and Address of Facility  |  | inski Funer                                     |                            |  |  |  |
|   |                 | to Spray  | A the death. De not out   | 1407 Old Eastern<br>er the mode of dying, such as cardiac                      | Avenue E   | Essex Maryla                                    |                            |  |  |  |
| Physician<br>/Medical   | 1 0             | failure. List only one cause on each line.  | i the death. Do not ent   | er the mode of dying, such as caldiac  | or respiratory arre                              | est, shock, of fleat                            | Between Onset and<br>Death |  |  |  |
| Examiner  |                 | mm diate Cause (Final dise se or ndition resulting in death)  a. Head Injuries  Due to (or as a constitution)   | equence of):  |  |  |   |                            |  |  |  |
| N-14  | ē               | Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons  | equence of);  |  |  |   |                            |  |  |  |
| hv  | Examiner        | cause. Enter Underlying Cause (Discass or injury that initiated events resulting in death) Last  Due to (or as a cons   | sequence of):   |  |  |   |                            |  |  |  |
| te be executed ysician and transit  |                 | d   | <del></del>   | 4-   |  |   |                            |  |  |  |
| 50,<br>te be ex<br>ysician  | <b>N</b> edical | UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome and the second of the | ime of pregnancy  |  |  | 23d Date of deliver                             |                            |  |  |  |
| ox 6876 eath certificate attending phy  |                 | 23b. Was decedent pregnant in the past 12 months?   | 2   | Fetal death 3 Ectopic pregr  | nancy  |   | Day Year                   |  |  |  |
| Box<br>e death c<br>the atten   | ysic            | 1 Yes 2 No 9 Unknown g Unknown  | t time or death 5   | Other (Specify)  |  | 1   |                            |  |  |  |
| that the ned by t   | by Phy          | Part II. Other significant conditions contributing to dea   | th but not resulting in t                                       | the underlying cause given in Part I.  |  | obacco use contribute to<br>s 2 ✓ No 3 Prol     |                            |  |  |  |
| ords, F<br>v requires<br>s been sig<br>should be  | eted            | \ <del></del>   |   |  | 24a. Was   |   | topsy findings available   |  |  |  |
| Recor<br>The law 1<br>cate has b  | Completed       |   |   |  | autop<br>perfor<br>1 ✓ Yes                       | rmed? death?                                    | completion of cause of     |  |  |  |
| Vital Recysician: The his certificate director, page  | Be C            | 25. Was case referred to medical examiner?  |   | 26 Place of Death (Check   |  |   |                            |  |  |  |
| f Vid<br>Physic<br>er this  | ဥ               | 1 V Yes 2 No Inpat  | ient 2 🗸 ER/Outpar  |  |  | Residence 6 Othe                                | <u> </u>                   |  |  |  |
| on of vending Physiath  | tion            | 1 Natural 5 Pending FOUND: Day  | Year) FOUND   | 1 10 103 2 110   | Truck slippe                                     | ed from forklift whil                           | e changing tire            |  |  |  |
| ivision  or Atteno after death Director:  | Certification:  | 3 Suicide 6 Could not be 28e. Place of  | Injury - At home, farm,   | street, factory, office building, etc.   | or Town, S                                       |   |                            |  |  |  |
| lospital<br>4 hours<br>uneral   |                 | 29a. Certifier Contifuing Physician: To the best of   | ·   | occurred at the time, date and place, ar                                       | 1  | ing Hwy - Seagirt I<br>se(s) and manner as star |                            |  |  |  |
| Division of Vital Records, P.O. Box 68760, within 24 hours after cleath. The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit | Medical         | one) 2 Medical Examiner: On the basis of ex<br>and manner states  | amination and/or inves  | stigation, in my opinion, death occurred                                       |  | and place, and due to the                       | e cause(s)                 |  |  |  |
| - 2 - 0   | ž               | 29b. Signature and title of certifier   |   | 29c. License number O.C.M.E.   |  | 29d. Date signed (Mo                            | nth, Day, Year)            |  |  |  |
|   |                 | (30. Name and address of person who completed cause of  | death (Item 23a)  |  |  | , , , , ,                                       |                            |  |  |  |
| N   |                 | Laron Locke MD. Assistant Medical Ex  | xaminer 111 P   | enn Street, Baltimore, MD 21   | 201  |   |                            |  |  |  |
| S   | tate            | 31. Date filed (Month, Day, Year) JUL 2 1 2006  | rar's Signature   | de   |  |   |                            |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** July 20, Lydia 2006 12:30A M Cherny /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1913 Tadcaster Road Baltimore Catonsville
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year July 8, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 378-32-3503 92 1914 Russia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23s or 28s-f show they injury or other traumatic event, the Madical Examiner must be notified at once. 1 ☐ Yes 2 ☐ No Be Completed by Funeral Director Catonsville MD **Baltimore** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1913 Tadcaster Road 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced white white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 4 Clerk Bank 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ciuicov Simion Anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mihail A. Galan - Husband 1913 Tadcaster Road Catonsville, MD 21228 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory July 22, 06 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road Baltimore, MD 21228 23a. Part1 Enter the disease, or complications that cause shock, or heart failure. List only one cause on each in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Belween Ooset and Death Immediate Cause (Final disease or condition resulting in death) 0515 **Physician** /Medical Due to (or as a consequence of) weeks Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Be Completed by Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 20 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after deat 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and TiNe of certifie 30. Name and address of persen who completed cause of death (Item 23a) (Type, Print) 3421 Benson Ave Bultimore, MD Douglas Pinto MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 21 2006 Registrar

|   |                          |  | State of Maryland  |                               |                                       |  | -   | _                             |   |  |  |
|---|--------------------------|--|--|-------------------------------|---------------------------------------|--|---|-------------------------------|---|--|--|
|   |                          | 1 - State Registrar  | olato or mary tarit  |                               | rtificate o                           |  | -   | Reg. No.                      | 6 22856   |  |  |
| Dhuai   | oioo                     | 1. Decedent's Name (First, Middle, Last)   |  |                               | 2. Date of De<br>Month                | ath  | 3. Time of Death  |                               |   |  |  |
| Physi<br>/Med   |                          | Bernadine Delores  |  | July                          |                                       |  | 9, 2006   | 12:28 P <sup>M</sup>          |   |  |  |
| Exam  | iner                     | 4a. Facility Name (If not institution, give so 5 Cassandra Ct  | treet and number)  |                               |                                       | , or Location of Deal                        | th  | 4c. County of Death Baltimore |   |  |  |
| Funera  | Coold County Number C.C. |  |  |                               | If Under 1 Yea                        |  |   |                               | 9. Birthplace (State or Foreign Country)  |  |  |
| Directo   |                          | 210 20 3422  | <sup>M 2</sup> ₹ 75  | Yrs.                          | Months Day                            | s Hours Min.                                 | DEC 9,  | 1930                          | Maryland  |  |  |
| and w   |                          | Usual Residence of Decedent  10a. State 10b. County  | 10c. City  | , Town or La                  | cation                                |  |   |                               | 10d. Inside City Limits   |  |  |
| Maryl<br>-1 ehc   | to                       | MD Baltimor  | re Ra  | anda1                         | 1stown                                |  |   |                               | 1 ☐ Yes 2 ☐ No  |  |  |
| th the  | Director                 | 10e. Street and Number   |  |                               | 10f. Zip Code                         |  |   | 10g. Citizen of Wh            | iat Country?  |  |  |
| USO  ours after death with the Maryland rel', or iteme 23s or 28s-f show Examiner must be mailled at    |                          | ) Cassandra Ci   |  |                               | 211                                   |  |   | USA                           |   |  |  |
| <u> </u>  | Funeral                  | 11. Marital Status 1  Never Married 2 Married  | <ol> <li>Was Decedent Ever in U.S<br/>Armed Forces?</li> <li>1 ☐ Yes 2 ♥ No</li> </ol> | 3. 13.                        | Was Decedent of<br>If Yes, specify Cu | f Hispanic Origin? (S<br>Joan, Mexican, Puer | Specify Yes or No<br>to Rican, etc.)  | 14. Race -<br>Bfack,          | - American Indian,<br>White, etc.   |  |  |
| 5-UUSO 72 hours after naturei', or ite  | þ                        | 3 Widowed 4 □ Divorced   | 1 ☐ Yes 2 X No<br>If Yes, Give<br>Year or Dates:                                       |                               | 1□Yes 2∏XN                            | o <i>Specify</i> :                           |   | Specify:                      | White   |  |  |
| 72 hc   | Completed                | 15. Decedent's Educ<br>(Specify only highest grade   | ation completed)   | 16a. Deced                    | dent's Usual Occ                      | upation<br>ne during most of wo<br>red)      | rking   | 16b Kind of Business/Industry |   |  |  |
| within 100.   | l du                     | Elementary/Secondary (0-12)  | College (1-4or 5+)   |                               |                                       | _  |   | C 14 1 1                      |   |  |  |
| A 5 5 5   | BeCc                     | 17. Father's Name (First, Middle, Last)  |  | secu                          | rity G                                |  | me (First, Middle,  | State of Maryla               |   |  |  |
| <b>₽</b> ₽ ₽ ₽ •  | To B                     | Vernon F. Alty   | ater   |                               |                                       | Gerald                                       | line E.   | Kellv                         | 1 v   |  |  |
| GOTE, MATYIE<br>ges 1 and 2 should<br>to of Heelth and Mer<br>if item 27 is marks<br>or other traumatic | -                        | 19a. Informant's Name/Relationship (Typ  |  |                               |                                       | et and Number or R                           |   |                               |   |  |  |
| C, n<br>1 and<br>Heelth<br>m 27<br>ther t   |                          | Joseph Culotta  20a. Method of Disposition   | od Rd Ca   | tonsvi.                       | IIe, MD                               |  |   |                               |   |  |  |
| Pages<br>nent of<br>nort: if its  |                          | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)   | minuvai ii oiii State  |                               | sition (Name of<br>matory or other p  |  |   |                               |   |  |  |
| 교 등 등 등   | à                        | 21. Signature of Funeral Service License   |  |                               |                                       | y, Inc 7                                     |   |                               |   |  |  |
| D d d d d   | Bud                      | 1 C. Lidd 13   | /-   | 12                            | 99 Free                               | derick R                                     | d Balt  | imore. N                      | MD 21228  |  |  |
|   |                          | 23a. Part1. Enter the disease, or compfice shock, or heart failure. List only on   |  | . Do not ent                  | er the mode of d                      | ying, such as cardia                         | c or respiratory a  | rrest,                        | Approximate<br>Interval Between   |  |  |
| Physicial<br>/Medica  |                          | Immediate Cause (Final disease or condition resulting in death)  | CONGES   | TIV                           | 3H 3                                  | ART F  | AILUI   | RE                            | Onset and Death   |  |  |
| Examine   |                          | ſ  | Oue to (or as a consequ  | ence of):                     | ARTE                                  | ERY I  | 71566   | 756                           |   |  |  |
| بتعية   | ner                      | Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | ence of):  | 1110                          | , L                                   | 1761   | 72  |                               |   |  |  |
| be executed ician and burial-transit  | Examiner                 | Cause (Disease or injury that initiated events resulting in death) Last  |  |                               |                                       |  |   |                               |   |  |  |
|   | cai E)                   |  | Due to (or as a consequ  | ence of):                     |                                       |  |   |                               |   |  |  |
| - w - 0   |                          |  |  |                               |                                       |  |   |                               |   |  |  |
| U - 5-  | an/M                     | fF FEMALE:<br>23b. Was decedent pregnant   | Bc. ff yes, outcome of pregnan<br>1□Live birth 2 □ Fetal                               |                               | Ectopic pregnar                       | nev  |   | 23d. Date                     | of delivery   |  |  |
| . 0 0 0   | Physician/Med            | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4 Pregnant at time of de 9 Unknown   |                               | Other (specify)                       |  |   | Month                         | n Day Year  |  |  |
| Ords, F.O. requires that the een signed by the hould be detached.                                       | Ph                       | Part II. Other significant conditions cont   | tributing to death but not resul   | lting in the ur               | nderlying cause o                     | aven in Part I.                              | 23e. Did to   | obacco use contrib            | ute to the cause of death?  |  |  |
| w requires been sign should be  | od by                    | LLY PC D +   | ENSION   |                               |                                       |  | 1 Yes 2 No 3 Probably 4 Inhino  |                               |   |  |  |
| N & W N   | ompieted                 |  |  |                               |                                       |  | 24a. Was  | an 24b. We                    | ore autopsy findings available or to completion of cause of   |  |  |
| The The page  | Com                      |  |  |                               |                                       |  | autop<br>perfo  | med dea                       | or to completion of cause of ath?  Yes 2 No   |  |  |
| VITA<br>icien:<br>certific<br>ector.  | Be                       | 25. Was case referred to medical examiner?   | ospital:   |                               | 10                                    | 26. Place of De                              | ne  |                               |   |  |  |
| Phys of   | 5                        | 1)XYes 2 No  | 1   Inpatient 2   E  | P/Outpatien<br>28b. Time of   | 3000                                  | ther: 4 Nursing H                            |   | dence 6 Other                 |   |  |  |
| Attending r death.  | atior                    | 1 Maturaf 5 ☐ Pending 2 ☐ Accident investigation   | (Month, Day Year)  | Injury                        | W                                     | ork?<br>□Yes 2□No                            | 28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State) |                               |   |  |  |
| - 9   | ertification:            | 3 Suicide 6 Could not be 4 Homicide determined   | 28e. Place of fnjury - At hor building, etc. (Specify)                                 | me, farm, str                 | eet, factory, offic                   | в  |   |                               |   |  |  |
| Ditei or<br>urs afte  | O                        |  |  |                               | Character House                       |  |   |                               | INDA STATE OF THE |  |  |
| To the Hospitel or At within 24 hours after of To the Funerel Direc completely filled in by             | edicai                   | 29a. Certifier 1 Certifying Physical (Check only one)  | ician: To the best of my know<br>er: On the basis of examinati<br>and manner stated.   | vledge dadil<br>on and/or inv | vestigation, in my                    | time, data and place<br>opinion, death occi  | urred at the time,  | date and place, and           | or as stated.<br>d due to the cause(s)  |  |  |
| To the<br>within<br>To the  | ₹<br>E                   | 29b. Signature and title of certifier  |  |                               | 29c. Lice                             | nse number                                   |   | 29d. Date signed (            | Month, Day, Year)   |  |  |
|   |                          | > Fromerses S  | somo MD  |                               | 103                                   | 3836   | 5   | 7/19/                         | 2006  |  |  |
| 1   | P                        | 30. Name and address of person who cor   | mpleted cause of death (Item   | 23а) (Туре,                   | Print)<br>569 A                       | J. CHAR                                      | UES S   | ST TO                         | OWSON   |  |  |
| <u> </u>  | State                    | 31. Date filed (Month, Day, Year)  | 32 Registrar's Signat  | Aite 1                        | and t                                 |  |   |                               |   |  |  |
| Regis   | strar                    | JUL 2 1 200  | 6 Bear D   | 14                            |                                       |  |   |                               |   |  |  |

|   |   |                   | 1 - For State of Maryland /  | Department of Health and Mer Certificate of Death  | ntal Hygiene   | 7 6077 0007   |  |  |  |
|---|---|-------------------|--|--|--|---|--|--|--|
|   | Physici<br>/Medic<br>Examin   | al                | 1. Decedent's Name (First, Middle, Last)  LOVISE  4a. Facility Name (If not institution, give street and number)   | CHARLTON =   | Date of Death<br>Month Day   | Year 3. Time of Death 7, 2006 7, 2 PM                                       |  |  |  |
|   | Funeral<br>Director   |                   | HARBOR HOSPITAL  5. Social Security Number  6. Sex 1□M 3□F  64  Usual Residence of Decedent  | 134 LTIMORE irthday) If Under 1 Year If Under 24 Hrs. 8. Yrs. Months Days Hours Min.   | Date of Birth<br>(Month, Day, Year)<br>Ctober 5,   | 9. Birthplace (State or Foreign Country)<br>1941 North Carolina             |  |  |  |
| 1215-0036 within 72 hours after deeth with the Maryland ene. fore. Than "natural; or iteme 23s or 28e-f ehow the Medical Examinar must be notified at |   | Director          |  | wn or Location<br>dena<br>10f. Zip Code  | 10g. Citi  | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No zen of What Country?                 |  |  |  |
|   |   | by Funeral        | 8124 Riverside Drive  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 3 No If Yes, Give Yes or Dates:  | 21122  13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricc | an, etc.)  | 14. Race - American Indian,<br>Black, White, etc.<br>Specify:<br>White      |  |  |  |
| Maryland 2<br>nd 2 should be filed<br>bith and Mental Hygi<br>27 is marked other<br>r treumatic event, 1  | be filed within 72 ntal Hygiene. of other than "natevent, the Medici  | Be Completed      | (Specify only highest grade completed)  Elementary/Secondary (0-12)  10  College (1-4or 5+)  Se  17. Father's Name (First, Middle, Last)   | a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  1f- employed  18. Mother's Name (F  | Capt   | cain Dick's   |  |  |  |
|   | is 1 end 2 should<br>of Heelth and Mer<br>item 27 is marke<br>other treumatic   |                   | Cindy Irizarry - daughter 77  20a. Method of Disposition 20b. Place  | b. Mailing Address (Street and Number or Rural Richard Company Rd., Severn of Disposition (Name of ery, crematory or other place)  | oute Number, City on 1, MD 2114  |   |  |  |  |
| Baltimore,  | permit. Page<br>Department of<br>Important: If<br>any injury or   |                   | 21. Signature of Funeral Survice Licensee  | eral Home<br>1., Elkrid  | dje, Maryland<br>at MMP, INC.<br>dge, MD 21075   |   |  |  |  |
| Syeo, Charles are be executed whisten and the burial-transit  |   | ical Examiner     | 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the cons | Renal Failure<br>nonia<br>Chall Bladde   |  | Approximate Interval Between Onset and Death  Un Known                      |  |  |  |
| P.O. Box 68   | death certific<br>e attending p<br>od for use as  | Physician/Med     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown   | h 3 Ectopic pregnancy 5 Other (specify)  |  | 23d. Date of delivery<br>Month Day Year                                     |  |  |  |
| Records, P.   | The law requires thet the ate has been signed by the page 2 should be detache   | چ<br>ا            | Part II. Other significant conditions contributing to death but not resulting  | 1 ☐ Yes 2 [  |  |   |  |  |  |
| Vital Rec   | S S   | Be Completed      | 25. Was case referred to medical examiner?   | 26. Place of Death (C  | 24a. Was an autopsy performed?  1 Yes 2 No   | 24b. Were autopsy findings available prior to completion of cause of death? |  |  |  |
| Division of Vital of or Attending Physicien: 3 after death. Director: After this certifical din by the funeral director, p                            | To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | Certification; To | 1 Tes 2 TNO 1 A Inpatient 2 EH/C   | Time of Injury at Work?  M 28c. Injury at Work?  1 ☐ Yes 2 ☐ No  | ∂ □Other (Specify) y occurred  d Number or Rural Route Number,   |   |  |  |  |
|   | he Hospitel (in 24 hours al<br>he Funeral D<br>pletely filled i   | edical            | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge and manner stated.  | ge, death occurred at the time, date and place, and nd/or investigation, in my opinion, death occurred a   | curred at the time, date and place, and due to the cause(s) and manner as stated. gation, in my opinion, death occurred at the time, date and place, and due to the cause(s) |   |  |  |  |
|   | Tot Tot E   | ×                 | 29b. Signature and title of certifier  M D,  30. Name and address of person who completed cause of death (Item 23a)  | 29c. License number RES 000 (Type, Print) SUBHASH B  | 29d. Dat   | e signed (Month, Day, Year)  Ly 17 2006                                     |  |  |  |
|   | Sta   | ate.              | 30. Name and address of person who completed cause of death (frem 23a 300) South Hanoves St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature   | Reet, Baltimore  |  | 21225   |  |  |  |
|   | Regist  |                   | JUL 2 1 2006 Beauce  | R Carlo  |  |   |  |  |  |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#26. per MD 9857 7/21/06 TT

Amend item#26. Department of Health and Mental Hygiene [] [] []

For State

22858

| cian                        | Registrar  |  | Certificate of Death  |   |  |  |                                     | Reg. No.   |  |  |  |  |
|-----------------------------|--|--|---|---|--|--|-------------------------------------|--|--|--|--|--|
| dili                        | 1. Decedent's Name (First, Middle, Last)  Beulah Mae Caldwell  |  |   |   | 2. Date of Month   |  |                                     |  | <sup>ay</sup> 2006   | 3. Time of Death<br>9:35 p M                 |  |  |
| lical                       | 4a. Facility Name (If not institution, give  |  | T.T.  |   | 4b City Town   | or Location of Deat  |                                     | 13, 2006 9:35 p                                      |  |  |  |  |
| 4920 Schalk Rd. #1          |  |  |   | 4b. City, Town, or Location of Death Millers  |  |  |                                     | 40   | Carı   |  |  |  |
|                             | 5. Social Security Number 6. Sec. 11   | ex<br>□ м <b>Х</b> Х F   | (In yrs. last bi  | rthday)<br>Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs<br>Hours Min.  |                                     | irth<br>ay, Year                                     | 9. Bird<br>9. 7 Ten  | nplace (State or Foreigr<br>untry)<br>165566 |  |  |
|                             | Usual Residence of Decedent  |  | 00  |   |  |  | 2149.                               | J / 1  | 323  |  |  |  |
|                             | 10a. State 10b. County   |  | 10c. City, Tow  |   |  |  |                                     |  |  | 10d. fnside City Limits                      |  |  |
| ctor                        | Maryland Carroll   |  | На  | mpst  | ead  |  |                                     |  |  | 1 ☐ Yes 2 🕅 No                               |  |  |
| Oire                        | 10e. Street and Number   |  |   |   | 10f. Zip Code  |  |                                     | 10g. Ci  | itizen of What Co  | untry?                                       |  |  |
| 120                         | 1211 N. Main St.   |  |   |   | 2107   |  |                                     |  | U.S.A.   |  |  |  |
| Funeral Director            | 11. Marital Status   | 12. Was Decedent E<br>Armed Forces?<br>1 ☐ Yes 2 N   |   | 13. Wa  | as Decedent of<br>Yes, specify Cub   | Hispanic Origin? (S<br>an, Mexican, Puer   | Specify Yes or N<br>to Rican, etc.) | 10-  | 14. Race - Ame<br>Black, White   |  |  |  |
| ρ                           | 1 Never Married 2 Married 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:   |   |   | Yes 2 No   |  |                                     |  |  | nite   |  |  |
| lete                        | 15. Decedent's Ed<br>(Specify only highest gra   | lucation<br>de completed)  | 16a   | Give ki   | nt's Usual Occu<br>nd of work done   | pation<br>during most of wo<br>d)  | rking                               | 16b. F   | Kind of Business/  | industry                                     |  |  |
| Completed                   | Elementary/Secondary (0-12)  | College (1-4or 5-  | +) H  | ouse  |  | a)   |                                     | Homemaker  |  |  |  |  |
| To Be C                     | 17. Father's Name (First, Middle, Last) Horace Liton Day   |  |   |   |  | 18. Mother's Na  | me (First, Middle<br>Cy Jane        |  |  |  |  |  |
|                             | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Douglas Martin – son  19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1920 Schalk Rd. #1, Millers, Md. 21102 |  |   |   |  |  |                                     |  |  | lip Code)                                    |  |  |
| 9                           | 20a. Method of Disposition   | 20b. Place o   | 20b. Place of Disposition (Name of cemetary, crematory or other place)                                |   |  |  |                                     | ocation - City or                                    | Town, State  |  |  |  |
|                             | 1 ☑Burial 2 ☐ Cremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Specify   | Sharon   | haron Hills Cem, July 17,2006   |   |  |  |                                     | Dover, Delaware                                      |  |  |  |  |
|                             | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility Eckhardt Funeral of 3296 Charmil Dr. Manchester, MI  |  |   |   |  |  |                                     |  |  | _  |  |  |
|                             | Immediate Cause (Final   |  |   |   |  |  |                                     |  |  | Approximate Interval Between Onset and Death |  |  |
| n/Medical Examiner          |  |  |   |   |  |  |                                     |  |  |  |  |  |
| Physician/Me                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   |  |   |   |  |  |                                     | 23d. Date of delivery<br>Month Day                   |  |  |  |  |
| by                          | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use  |  |   |   |  |  |                                     | use contribute to the cause of death?                |  |  |  |  |
| e                           | a p  |  |   |   |  |  | perl                                | utopsy prior to completion of cause of death?        |  |  |  |  |
| ompl                        |  | 25. Was case referred to medical 26. Place of Death (C   |   |   |  |  |                                     |  |  |  |  |  |
| Be Completed                | 25. Was case referred to medical examiner?   |  | axaminer /  |   |  |  |                                     |  | 6X Other (Spec   | n s Resider                                  |  |  |
| To Be                       | examiner?<br>1 ☐ Yes 2 ☑ No  | 1 🗆 Inpatier   |   | utpatient   | 3□ DOA   | 4 Nursing l  | nome -b                             | ilderice   | tient 3 DOA Other: 4 Nursing Home S Posidence Mother (Specify)  28c. Injury at Work?  M 1 Yes 2 No |  |  |  |
| To Be                       | examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  | 28a. Date of fnjur<br>(Month, Day  |   | Itpatient<br>Time of<br>Injury  | 28c. Inju<br>Wo  | ry at<br>rk?   |                                     |  |  |  |  |  |
| To Be                       | examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending  | 28a. Date of fnjur<br>(Month, Day  | y 28b.  | Time of<br>Injury   | M 1  | ry at<br>rk?   | 28d. Describe                       | Street a   | ary occurred  nd Number or Ru  | ral Route Number,                            |  |  |
| Certification: To Be        | examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 2 Accident investigation 3 Suicide determined  29a. Certifier 1 Certifying Ph  | 28a. Date of Injur (Month, Day   | y Year) 28b.  Iny - At home, for the control of my knowledge examination are                          | Time of Injury  arm, stree  | 28c. Inju Wc M 1 =   | ry at<br>rk?<br>]Yes 2 □ No<br>me date and place                                 | 28f. Location City or To            | (Street a  | nd Number or Ru e)   | stated                                       |  |  |
| To Be                       | examiner?  1   | 28a. Date of fnjur (Month, Day  28e. Place of Injur building, etc  28i. To the best of the day of t | y Year) 28b.  Iny - At home, for the control of my knowledge examination are                          | arm, stree  | M 28c. Inju Wcc  pt, factory, office  accourred at the testigation, in my  29c. Licen  | ry at rk? Yes 2 \( \text{No} \) me, date and place opinion, death occesse number | 28f. Location City or To            | (Street a<br>cown, State<br>cause(s                  | nd Number or Ru e)   | stated.<br>to the cause(s)                   |  |  |
| edical Certification: To Be | examiner?  1   | 28a. Date of Injur (Month, Day) 28e. Place of Injur building, etc  28i. To the best of and manner sta  | y Year) 28b.  Iny - At home, for (Specify)  If my knowledge examination arted.                        | Time of Injury  arm, stree  | M 28c. Inju Wc 1 C at, factory, office occurred at the testigation, in my 29c. Licen   | ry at rk? Yes 2 \( \text{No} \) me, date and place opinion, death occesse number | 28f. Location City or To            | (Street a<br>cown, State<br>cause(s                  | nd Number or Ru  e)  s) and manner as d place, and due ate signed (Month                           | stated.<br>to the cause(s)                   |  |  |
| edical Certification: To Be | examiner?  1   | 28a. Date of fnjur (Month, Day 28e. Place of Injur building, etc.  28i. To the best of and manner sta.   | y Year) 28b.  Iny - At home, for (Specify)  If my knowledge examination and ted.  Lical Door and ted. | Time of Injury  Time of Injury  Arm, street, death of Indoor inventions  (Type, Prince of Injury) | M 28c. Inju Wc 28c. Inju Wc 28c. Inju Wc 28c. Inju Wc 28c. Licen 29c. Licen 2 | ry at rk? IYes 2 No me, date and place opinion, death occurse number             | 28f. Location City or To            | (Street and own, State of cause(s), date and 29d. Da | and Number or Ru  s) and manner as d place, and due  ate signed (Monti                             | stated. to the cause(s)  Day, Year)          |  |  |

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** July 15, 2006 2:26am Margaret Combs /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson TOWSOII

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Months, Days Hours Min. | Nov. 1, 1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 ☐ M 2 💢 F 80 MD Director 220-20-6395 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov other treumatic event, the Medical Examiner must be notified at Baltimore 1 Yes 2 No Director Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 8102 Bletzer Road 21222 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2t No Specify: Specify: 3 TWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 9 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Henry Lutz ٩ Halsie Hile 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward D. Ford - Son 2816 Munster Road, Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 7-22-06 Rosedale, MD 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Fyneral Service Licens PA, 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death TRICULAR Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner KALEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner THROMBOSIS attending physicien and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by cete hes been signe, pege 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2★ No certificete within 24 hours after deeth. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 No 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how intury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Scentifying Physician: To the best of my knowledge, doubt consumed at the time, date and plane, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Nam 31. Date filed (Month, Day, Year) State JUL 2 1 2006 Registrar

|                     |  |                   | For<br>State<br>Registrar  | State of Marylan  |                  |   | of Health a                        | and M                 |                                   | jiene             | 06                  | 228                          | 60            |
|---------------------|--|-------------------|--|---|------------------|---|------------------------------------|-----------------------|-----------------------------------|-------------------|---------------------|------------------------------|---------------|
|                     |  |                   | Negistrar     Negeodent's Name (First, Middle)                               | Last)   |                  |   |                                    |                       | 2. Date of Dear                   | th                |                     | 3. Time of I                 | Death         |
|                     | Physicia   | in                | Kirster  | Craw ford   |                  |   |                                    |                       | Month                             | Day               | Yeer                | 2:10                         | AM            |
|                     | /Medic   | _                 | 4a. Facility Name (If not institution,                                       |   |                  | 4b. City. Tow                                     | vn, or Location o                  | of Death              | 7519                              | 4c. County        |                     | 22710                        |               |
|                     | Examin   | er                | Mercy medic  |   |                  | 3   |                                    |                       |                                   | Ral               | Smo                 | e CA                         |               |
|                     | Suppose  |                   |  | 6. Sex 7. Age (In yrs.  | last birthday)   | If Under 1 Y                                      |                                    | 24 Hrs.               | 8. Date of Birth                  |                   |                     | place (State or              | Foreign       |
|                     | Funeral<br>Director  |                   |  | 1 M 2 F   | Yrs.             | Months Da   | ays Hours                          | Min.                  | July 16                           |                   |                     | ary land                     |               |
|                     |  |                   | Usuel Residence of Decedent  |   |                  |   |                                    |                       | J .                               |                   |                     | 7                            |               |
|                     | ylan   |                   | 10a. State 10b. County   | i   | ty, Town or Lo   | ocation   |                                    |                       |                                   |                   | 1                   | IOd. Inside City             |               |
|                     | a-1-e  | to                | Mayland Bal  | Homore &  | ssex             |   |                                    |                       |                                   |                   |                     | 1 🗆 Yes                      | SIMNO         |
|                     | or 28  | Director          | 10e. Street and Number   |   |                  | 10f. Zip Co                                       |                                    |                       | 1                                 | log. Citizen of V | Vhal Cou            | ntry?                        |               |
|                     | 23a 23a  |                   | 978 Sandow   | good Road   |                  |   | 21221                              |                       |                                   | u                 | SA                  |                              |               |
|                     | ems<br>ems   | Funeral           | 11. Marital Status   | 12. Was Decedent Ever in U<br>Armed Forces?   | I.S. 13.         | Was Decedent                                      | of Hispanic Orig<br>Cuban, Mexican | gin? (Spe<br>, Puerto | ecity Yes or No-<br>Rican, etc.)  | 14. Rac<br>Blac   | e - Americk, While, | can Indian,<br>etc.          |               |
| ထ္ထ                 | or It  | F                 | 1 Never Married 2 Marrie   | If Yes, Give  |                  | 1 ☐ Yes 2 ☐                                       | No Specify:                        |                       |                                   | Specify           | . B1                | ack                          |               |
| ğ                   | within 72 hours after death with the Maryland<br>ene.<br>Than "natural", or items 23a or 28a-f ehow<br>the Maulcal Examinar must be notified at  | d by              | 3 Widowed 4 Divorced   | Year or Dates:  | 10- D            | 4   |                                    |                       |                                   | 10h Kind of B     |                     | dual a                       |               |
| 4                   | nat<br>nat   | Completed         | 15. Decedent<br>(Specify only highes   |   | (Give            | deni's Usual O<br>kind of work d<br>DO NOT use re | one durina most                    | t of worki            | ing                               | 16b, Kind of Bu   | JSINOSS/IN          | dustry                       |               |
| 2                   | withir   | g l               | Elementary/Secondary (0-12)  | College (1-4or 5+)  | •                | nt  | omocy                              |                       | ,                                 | infant            |                     |                              |               |
| 2                   | filed with<br>Hygiene<br>other than  | S                 | 17. Father's Name (First, Middle, I  | Last)   | 1                | <u> </u>  | 18. Mothe                          | r's Name              | (First, Middle, I                 | Maiden Suman      | 10)                 |                              |               |
| Maryland 21215-0036 | Mental<br>Merked o<br>arked o  | o Be              | James Do   | orsey Craw ford   |                  |   | X.                                 | oren                  | And                               | anetta            | G                   | or-land                      | ^             |
| 2                   | should.<br>and Men<br>is marks   | 2                 | 19a Informant's Name/Relationsh  | 3   | 19b. Maili       | na Address (St                                    |                                    |                       | al Route Number                   |                   | State, Zip          | Code)                        | 1             |
| S                   | ith ar<br>ith ar<br>27 Is<br>1 Treu  |                   | Koren Crawfa   | J/mo  | 979              | 50  | ndalwood                           | 1                     | Road                              | 988es             | m                   | aryland                      | 21221         |
| ā,                  | tem 27   | ŀ                 | 20a. Method of Disposition   | 20b. F  | Place of Dispo   | sition (Name of                                   | of                                 |                       | 100                               | 20c. Location -   |                     |                              |               |
| more,               | Pages<br>nent of I<br>int: If its<br>iry or o  |                   | 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp                            | 3 Hemoval from State  |                  |   |                                    | 1/20                  | 1/2006                            | BALTIM            | ~PC                 | 200                          |               |
| alti                | 그 본 관 등  |                   | 21. Signature of Funeral Service   |   |                  | 2. Name and A                                     | ddress of Facilit                  | 7                     | 34 Wil                            |                   |                     | RD                           |               |
| Ba                  | Departing on its in the parting of its in th |                   | Hosto. I   | - LOUS.   | 0                | RADLEY  | - ASHID                            |                       | LPA.                              |                   |                     | MD, Z                        | 1777          |
|                     |  |                   | 23a. Part1. Enter the disease, or  | complications that caused the deat  |                  |   |                                    | -                     | or respiratory arr                |                   |                     | Approximate                  | )             |
|                     |  |                   | shock, or heart failure. List of<br>Immediate Cause (Final                   | only one cause on each line.  | 0                |   | )                                  |                       |                                   |                   |                     | Interval Betw<br>Onset and D |               |
|                     | Physician<br>/Medical  |                   | disease or condition resulting in death)                                     | Due to (or as a consec  |                  | rematu  | MA                                 |                       |                                   |                   |                     |                              |               |
|                     | Examiner   |                   |  | Pale  |                  | labor   |                                    |                       |                                   |                   |                     | 1 hour 3                     | 39 min        |
|                     | As a   | ē                 | Sequentially list conditions, if any, leading to immediate                   | b. Due to (or as a consec   |                  | (VCEW)  |                                    |                       | <del></del>                       |                   |                     |                              | - 11000       |
|                     | uted<br>ansit  | m<br>L            | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events | Char  | ipami            | rioniti   | S                                  |                       |                                   |                   |                     |                              |               |
| Ć,                  | n and  | Examiner          | resulting in death) Last   | Due to (or as a consec  |                  |   |                                    |                       |                                   |                   |                     |                              |               |
| 8760,               | death certificate be executed<br>e attending physician and<br>od for use as the burial-transit   |                   |  | d   |                  |   |                                    |                       |                                   |                   |                     | <u> </u>                     |               |
| 89                  | ificati<br>g phy<br>as the   | Physician/Medical |  |   |                  |   |                                    |                       |                                   |                   |                     |                              |               |
| Вох                 | that the death certific<br>ed by the attending p<br>detached for use as  | N                 | IF FEMALE:<br>23b. Was decedent pregnant                                     | 23c. If yes, outcome of pregn.  |                  | ∃Edlopic pregn                                    | 2001                               |                       |                                   | 23d. Dai          | te of deliv         | ,                            |               |
| Ω.                  | death<br>e atte  | Icla              | in the past 12 months?<br>1 ☐ Yes 2 ☑ No                                     | 4□Pregnant at time of c   |                  | Other (specif                                     |                                    |                       |                                   | Mo                | nth                 | Day Y                        | 'ear          |
| O.                  | t the<br>by th<br>tache  | hys               | 9 🗆 Unknown  | 9□ Unknown  |                  |   |                                    |                       |                                   |                   |                     |                              |               |
| ري<br>ص             | The law requires that the to be been signed by the bage 2 should be detached.  | ру Р              | Part II. Other significant condition   | ons contributing to death but not res   | sulling in the u | inderlying caus                                   | e given in Part I.                 |                       |                                   | bacco use conf    |                     |                              |               |
| Ď                   | w requires t<br>been signe<br>should be  |                   |  |   |                  |   |                                    |                       | 1 🗆 Y                             | es 2 PNo          | 3 Prot              | oably 4 □U                   | nknown        |
| 000                 | lawre<br>as bed<br>2 sho   | plet              |  |   |                  |   |                                    |                       | 24a. Was a autops                 | in 24b.           | Were auto           | psy findings a               | ivailable     |
| Vital Records,      | The lay  | Completed         |  |   |                  |   |                                    |                       | perform                           | med?              | death?              |                              | .030 01       |
| <u>ia</u>           | rtifica  | 0                 | 25. Was case referred to medical   |   |                  |   | 26. Place                          | of Death              | (Check only or                    |                   |                     |                              |               |
| >                   | Physicien:<br>r this certific<br>ral director,   | To B              | examiner? 1 Yes 2 No   | Hospital: 1 Inpalient 2   | ER/Outpatie      | nt 3 DOA  | Other: 4 Nu                        | rsing Ho              | me 5 Reside                       | ence 6 🗆 Oth      | er (Specil          | (y)                          |               |
| ٥٥                  | ig Ph<br>ter th  |                   | 27. Manner of Death 1 ☑Natural 5 ☑ Pending                                   | 28a. Dale of Injury<br>(Month, Day Year)  | 28b. Time o      | f 28c.  | Injury al<br>Work?                 |                       | 28d. Describe h                   | ow injury occurr  | red                 |                              |               |
| <u>0</u>            | Attending<br>r death.<br>ector: Atter<br>by the fune   | atic              | 2 Accident investig  | gation  |                  | М   | 1 Yes 2 1                          | No                    |                                   |                   |                     |                              |               |
| Division            | er de<br>recto   | Certification:    | 3 Suicide 6 Could n<br>4 Homicide determ                                     |   | nome, farm, st   | reet, factory, of                                 | fice                               |                       | 28f. Location (Si<br>City or Town |                   | er or Rura          | al Route Numb                | )0 <i>(</i> , |
|                     | rs after<br>al Dire  | Cer               |  |   |                  |   |                                    |                       |                                   |                   |                     |                              |               |
|                     | To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page   | edical            |  | ng Physician: To the best of my knot<br>Examiner: On the basis of examination<br>and manner stated. |                  |   |                                    |                       |                                   |                   |                     |                              |               |
|                     | To the within 2 To the complet   | Med               | 29b. Signature, and title of certifier                                       |   |                  | 29c. Li   | cense number                       |                       | 2                                 | 29d. Date signe   | d (Month,           | Day, Year)                   |               |
| )                   | F ≤ F ö  |                   | ) Kat (  | apple me  | >                | D   | 20604                              | 113                   |                                   | 7/16/             | 200                 | 6                            | ;             |
|                     |  |                   | 30 Name and address of person  | who completed cause of death (Ite   | m 23a) (Tvna     | Print)  |                                    |                       |                                   | 1(                |                     |                              |               |
| /                   | $\langle$  |                   | Latter AL  | ullo 301  |                  |   | lace                               | Ber                   | Homere                            | MP                | 21                  | 202 -                        | 2165          |
|                     | Sta  | te                | 31. Date filed (Month, Day, Year)  | 32. Pagistrar's Sign  |                  |   |                                    |                       |                                   |                   |                     | -                            |               |
|                     | Regist   |                   | 31. Date filed (Month, Day, Year)  | 1 2005 Seeger   | 1. 1             | neste   |                                    |                       |                                   |                   |                     |                              |               |

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 07/14/2006 9:05 Elizabeth Childress /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Bon Secours Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2□F Yrs. Director Maryland 96 July 5, 1910 216-24-1120 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir then "naturel", or Iteme 23a or 28a-f show tre Madigal Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 <u>United States</u> 4305 B Wilkens Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White by 3∑ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) N/A Secretary Oil Company 10 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Ie marked otheny injury or other traumatic event 90ce. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louis Dorn Mary Neubauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12075 Susan Lane, Lusby, Meryland 20657

20b. Place of Disposition (Name of cometery, crematory or other place)

Date 20c. Location · City or Town, State Angela J. Burgess (Niece)
20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Redeemer Cemetery 07/18/2006 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature Fundra Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNUEMONIA **Physician** DAYS /Medical Due to for as a consequence of) Examiner RENA2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine as the burial-transit ARTERIOSCLEROTIL UNICNOWA Box 68760 MYPERTENTION Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9☐ Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ØUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? MALNUTRITION autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 🕅 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) the Funeral Director: After the mpletely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending 1 Natural 1 Yes 2 No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. D 23300 JULY 14 2006 BON SECOURS NOSP, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATE2 SUDHIR ND. 20000 BALTUSTI BALTO 31. Date filed (Month, Day, Year) 32 Aegistrar's Signature State Oracle JUL 2 1 2006 Dece Registrar

06-04936 Andrew Curley

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

|  | 1              | 1- For State<br>Registrar  |   | tificate of                          |   |                                       | F                                  | Reg No. 2                                | 006 2286   |
|--|----------------|--|---|--------------------------------------|---|---------------------------------------|------------------------------------|--|--|
| Physicia<br>edical Exami   | n/             | 1. Decedent's Name (First, Middle,La   |   | <del>irley</del>                     |   | 2. Date of Dea<br>Month<br>July 11, 2 | Day Year<br>2006                   | 0918 hrs                                 |  |
|  |                | 4a. Facility Name (if not institution, gi<br>Johns Hopkins Hospital  | ve street and number)   | 4                                    | b. City, Town, or l<br>Baltimore                  |                                       |                                    | 4c. County c                             | N/A  |
| Funeral<br>Director  |                | 0,0,000  |   | ast birthday)                        | If Under 1 Year Months Days                       | If Under 24Hi<br>Hours Mi             | s. B. Date of B                    | 9, 1989                                  | 9. Birthplace Claster<br>Foreign District<br>Office Columbia                   |
| nd<br>show any<br>ce.  |                | Usual Residence of Decedent  10a. State 10b. County  Md. Bal   | 10c. City,  | Town or Locati                       | Monktor   |                                       |                                    |  | 10d Inside City Limits 1 Yes 2 No  |
| with the Maryland<br>ms 23a or 28a-f show<br>be notified at once.  | Dire           | 10e. Street and Number 16949 Wesley Ch   |   |                                      | 10f. Zip Code <b>21</b>                           |                                       |                                    | 10g. Citizen of Wh                       | at Country?<br>ISA   |
| r death<br>or ite  | Funeral        | 11 Marital Status 1 X Never Married 2 Marrie   | 1 Yes 2 X No  |                                      | s Decedent of Hisp<br>es, specify Cuban,          | Mexican, Puert                        |                                    | White                                    |  |
| 21215-0036  Muld be filed within 72 hours after than Hygiene market other than "natural", cevent, the Medical Examiner   | <u>a</u>       | 3 Widowed 4 Divorce  15. Decedent's Education (Specify of Elementary/Secondary (0-12)                                      | If Yes, Give Year or Dates: only highest grade completed)  College (1-4 or 5+)              |                                      | Yes 2 No<br>'s Usual Occupations of working life. | on (Give kind of                      |                                    | Specify  16b. Kind of Bus                | White siness/Industry  |
| 21215-0036 uld be filed within 7. Mental Hygiene marked other than c event, the Medical  | Completed      | 10<br>17. Father's Name (First, Middle, Las  | t)  |                                      | Studer<br>1                                       |                                       | ne (First, Middle,                 | Edu<br>Maiden Surname)                   | cation   |
| 21215<br>hould be fill<br>and Mental F<br>is marked  | To Be          | Michael 19a. Informant's Name/Relationship (   |   | 19b. Mailing                         | Address (Street                                   |                                       | arbara<br>Rurai Route Nu           | Ann From                                 | n, State, Zip Code)  |
| MC and 2 slath ar  |                | Michael Curley/Fa 20a. Method of Disposition 1 Burial 2 X Cremation 3  | 20b. F  |                                      | tion (Name of cerr                                |                                       | Road Mo<br>Date                    |  | laryland 21111<br>City or Town, State  |
| Baltimore,<br>permit Pages I a<br>Department of He<br>Important: If ite  |                | 4 Donation 5 Other Specification 21. Signature of Funeral Service Line   | y: Hill   |                                      | rvice Co<br>ame and Address                       | of Facility R                         |                                    | on Funer                                 | Maryland<br>al Home, Inc.  |
| Physician /Medical   |                | 23a Part I Enter the disease, or comfailure. List only one cause on o  | each line   | Do not enter the                     |   | such as cardiac                       |                                    | Maryland<br>rest, shock, or hea          | Approximate Interval<br>Between Onset and                                      |
| Examiner   |                | Immediate Cause (Final disease or condition resulting in death)  | Due to (or as a consequence of  |                                      | th complica                                       | ations                                |                                    |  | Death  |
|  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated | Due to (or as a consequence of  |                                      |   |                                       |                                    |  | 25   |
| xecuted<br>n and<br>l - transit  |                | events resulting in death) Last  X UNPENDED  | Due to (or as a consequence of AMENDED #1, perM   |                                      | .0/25/06 TI                                       | 1                                     |                                    |  |  |
| 8760,<br>ificate be executed<br>ng physician and<br>as the burial – transi   | 5              | IF FEMALE:<br>23b. Was decedent pregnant in the  | 23c. If yes, outcome of pregi   |                                      | 0/25/06 TI<br>28a-f, perME<br>al death 3 [        | E <b>,</b> g858,8/2                   |                                    | 23d. Date of Month                       | delivery Day Year  |
| Box 687  re death certification and the attending and the ast of the set of t | Physiciar      | past 12 months?  1 Yes 2 No 9 Unknow   | 4 Pregnant at time of de  | ath 5 Otl                            | ner (Specify)                                     |                                       |                                    |  |  |
| s, P.O.<br>uires that the<br>n signed by   | b              | Part II. Other significant conditions  | contributing to death but not re  | esulting in the u                    | nderlying cause g                                 | Iven in Part I                        | . 1 Ye                             | es 2 No 3                                | probably 4  Unknown  |
| Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death corrisonal for the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detachted for use as  | Completed      |  |   |                                      |   |                                       | 24a Was<br>auto<br>perfi<br>1  Yes | psy pormed? d                            | Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No |
| tal Rection: The certificate ector, page   | Be             | 25. Was case referred to medical examiner?   | Hospital:   |                                      |   | of Death (Chec                        |                                    |  |  |
| f Vi<br>Physic<br>er this<br>real dir  | ပ              | 1 Yes 2 No<br>27. Manner of Death  | Hospital: 1 ✓ Inpatient 2  28a. Date of Injury  | ER/Outpatient<br>28b. Time of I      |   | y at Work?                            | ing Home 5                         | Residence 6 how injury occurre           | Other:   |
| on on and ing the refunction of the function o | tion:          | 1 Natural 5 Pending  | (Month, Day, Year) Fpd. 7/5/2006  | Fnd 12:0                             |   | es 2 X No                             | unk                                | , ,                                      |  |
| Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the  | Certification: | 2 Accident Investigate 3 Suicide 6 X Could not determine   | 28e. Place of Injury - At he  |                                      | et, factory, office b                             | - 11                                  | 28f. Location or Town,             | (Street and Number<br>State) 16949       | er or Rural Route Number, City<br>Wesley Chapel                                |
| D<br>To the Hospital<br>within 24 hours<br>To the Funeral  | cal            | 29a Certifier 1 Certifying Physical Cone) 2 Medical Examin   | ician: To the best of my knowled<br>er: On the basis of examination a<br>and manner stated. | ge, death occur<br>and/or investigat | red at the time, da<br>ion, in my opinion,        | te and place, ar<br>death occurred    | nd due to the cau                  | ise(s) and manner<br>a and place, and du | as started<br>ue to the cause(s)   |
| F 3 F 8  | Medi           | 29b. Signature and title of certifier  | sell MA   |                                      | 29c License<br>O.C.M                              |                                       |                                    | July 13, 200                             | d (Month, Day, Year)<br>06   |
| ~  |                | Melissa Brassell, MD   | o completed cause of death (Item<br>Assistant Medical Examir                                | ner 111 F                            | enn Street, B                                     | altimore, MI                          | D 21201                            |  |  |
|  | tate<br>trar   | 31. Date filed (Month, Pay, geat) 2  | 32 Registrar's Signatu  | K Ana                                | 60  |                                       |                                    |  |  |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

|                |   | •                | . 101  | Department of Health and Certificate of Death  | Mental Hygier<br>Reg. P              | 7000 77000   |
|----------------|---|------------------|--|--|--------------------------------------|--|
|                |   |                  | Decedent's Name (First, Middle, Last)  |  | 2. Date of Death                     | Day Year 4 4 2 00  |
|                | Physici:<br>/Medic  | _                | Constance H. Dyer  |  | July 1                               | 8, 2006 11.20am.   |
| 1              | Examin  |                  | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Deat  | h /                                  | 4c. County of Death  |
|                |   |                  | St. Ugnes Health Care  | baltimore  |                                      | N/A  |
|                | Funeral   |                  | 5. Social Security Number 6. Sex 7. Age (In yrs. last bin  | hday) If Under 1 Year If Under 24 Hrs  Months Days Hours Min.  | (Month, Day, Yea                     | 9. Birthplace (State or Foreign Country) Maryland                    |
|                | Director  |                  | 219-40-8296 62 Usual Residence of Decedent   |  | Oct. 9, 1                            | .943   Maryland  |
|                | yland   |                  | 10a. State 10b. County 10c. City, Town   | or Location  |                                      | 10d. Inside City Limits  |
|                | Mar<br>B-f el   | to               | MD N/A   | Baltimore  |                                      | 1√2 Yes 2 □ No   |
|                | or 28   | Funeral Director | 10e. Street and Number   | 10f. Zip Code  | 10g. (                               | Citizen of What Country?   |
|                | 23a   | la               | 620 Markham Road   | 21229  |                                      | United States  |
|                | teme  | rue              | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  | <ol> <li>Was Decedent of Hispanic Origin? (S<br/>If Yes, specify Cuban, Mexican, Puer</li> </ol>   | pecify Yes or No-<br>to Rican, etc.) | 14. Race - American Indian,<br>Black, White, etc.                    |
| 36             | s afte  | by F             | 1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:  | 1 ☐ Yes 2 No Specify:  |                                      | Specify: White   |
| 21215-0036     | within 72 hours after death with the Maryland jiene.<br>rthan "naturel", or Iteme 23a or 28e-f ehow<br>the Medical Examiner must be notified at               | ed               |  | Decedent's Usual Occupation  | 16b.                                 | Kind of Business/Industry  |
| 215            | 72 nin 72   | piet             | (Specify only highest grade completed)   | (Give kind of work done during most of wollife. DO NOT use retired)  | rking                                | ,  |
| 212            | TO 100 100 100 100 100 100 100 100 100 10   | Completed        | Elementary/Secondary (0-12) College (1-4or 5+)   | Office Clerk   |                                      | Transportation   |
| 5              | be filed<br>tal Hygi<br>d other<br>event, I   | Bec              | 17. Father's Name (First, Middle, Last)  | 18. Mother's Na  | ne (First, Middle, Maid              | en Sumame)   |
| <u>Ja</u>      |   | ဥ                | Rennard S. Hutchinson  | Ina C.   | Williams                             |  |
| Maryland       | and<br>man  |                  | 1177   | Mailing Address (Street and Number or Ru   |                                      |  |
|                | is 1 and 2<br>of Health<br>item 27 i  | 1                |  | 620 Markham Road, Ba   |                                      | D 21229<br>Location - City or Town, State                            |
| Baltimore,     | 8 5 -   |                  | Cemeter Communication Communic | y, crematory or other place)   |                                      | Location - City or Town, State                                       |
| 듩              | permit. Page<br>Department of<br>Important: If<br>any injury or<br>ance.  | 1                | 4 Donation 5 Other (Specify)  21. Signitus of Funda Service Licence  |  |                                      | 1timroe, MD  |
| Ba             | permit. Departr Imports any inju  |                  | MONON CONON  | 22. Name and Address of Facilia mb 1   |                                      | •  |
|                |   |                  | 23a. Part1. Enter the disease, or complications that caused the death. Do r  |  | Approximate                          |  |
|                | Dhusisian   |                  | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final   | · · · · · · · · · · · · · · · · · · ·  | trice L                              | Interval Between<br>Onset and Death                                  |
| je             | Physician<br>/Medical   |                  | disease or condition resulting in death)  a. Now 5 Mu   Cell C   | orcinoma metas   | ouses v                              | o brain sweek  |
| П              | Examiner  | Ì                | Conventially list and divings  |  |                                      |  |
|                | p =   | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   | of):   |                                      |  |
|                | ecute<br>and<br>-trans  | Examine          | Cause (Disease or injury that initiated events c   | 4).  |                                      |  |
| 60,            | icate be executed<br>physicien and<br>the burial-transit  | aj<br>E          | Due to (of as a consequence of   | n).  |                                      |  |
| 68760,         | phys<br>phys<br>s the   | dicai            | d  |  |                                      |  |
|                | eath certifi<br>ettending  <br>for use as   | /Me              | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy  |  |                                      | 23d. Date of delivery  |
| Вох            | death<br>e etter  | clar             | in the past 12 months?  1  Yes 2 No  | 3 □Ectopic pregnancy 5 □ Other (specify)   |                                      | Month Day Year   |
| 0              | by the de   | Physician/M      | 9 Unknown  |  |                                      |  |
| ď              | Physician: The law requires thet the death certifi<br>this certificate has been signed by the ettending<br>rat director, page 2 should be detached for use as | by P             | Part II. Other significant conditions contributing to death but not resulting in   | /// / / //   |                                      | o use contribute to the cause of death?                              |
| Vital Records, | w require<br>been sign  | be               | (hron: CObstructi  | ve / ulvuray //v.  | 1 Types                              | 2 No 3 Probably 4 Unknown  |
| 20             | law ra<br>as be<br>2 sh   | Completed        |  |  | 24a. Was an autopsy                  | 24b. Were autopsy findings available prior to completion of cause of |
| <u>~</u>       | : The law<br>cate has I   | Ö                |  |  | performed?                           | death?   |
| ia<br>ia       | iclan: Th<br>certificate<br>rector, pag   | Be (             | 25. Was case referred to medical examiner?   | 26. Place of De  | ath Check only                       |  |
| 产              | Phyei<br>this o<br>al dire  | ၉                | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 XER/Ou  | The state of the s | fome 5 Residence                     |  |
| E C            | ding P.<br>After<br>funera  | on in            | 1 Natural 5 ☐ Pending (Month, Day Year) I  | ime of 28c. Injury at Work?  | 28d. Describe how in                 | jury occurred  |
| isi            | or Attending<br>efter death.<br>Director: After<br>in by the fune   | icat             | 2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, fa   | M 1 Yes 2 No   | 28f Location (Street                 | and Number or Rural Route Number,                                    |
| Division of    | or A<br>efter<br>Direct   | Certification:   | 4 Homicide determined building, etc. (Specify)   | mir, street, factory, omce   | City or Town, Sta                    | are)   |
|                | spite<br>nours<br>nerel   |                  | 29a. Certifier 12 Certifying Physicien: To the best of my knowledge  | , death occurred at the time, date and place   | , and due to the cause               | (s) and manner as stated.  |
|                | To the Hospitel or Attenwithin 24 hours efter deatl To the Funerel Director:  | Medical          | (Check only and manner stated.  (Check only one)  2 Medical Examiner: On the basis of examination an and manner stated.  | d/or investigation, in my opinion, death occu  | irred at the time, date a            | and place, and due to the cause(s)                                   |
|                | To t<br>To tl   | Σ                | 29b. Signature and title of certifier  | 29c. License number  | 29d. 0                               | Date signed (Month, Day, Year)                                       |
|                | 4   |                  | P P P  | N00 273  | 15 Ju                                | 14 18, 2000  |
| ,              | ኝ <b>`</b>  |                  | 30. Name and address of person who completed cause of death (Item 23a)   | Type, Print)   | 1 1                                  | 14 18, 2006<br>1, Baldimore  |
|                | <i></i>   |                  | 31. Date filed (Month, Day, Year), 100 32, Registrary Signature  | Jt. Hynes &  | 10761 A.                             | 1 104/dimore   |
|                | Sta<br>Registi  |                  | 31. Date filed (Month, Day, Year) 2006 Registrar's Signature   | ADMACA "   | •                                    |  |

|  |                     | State of Maryland / Departmen  1 - State Registrer Certificate   | t of Health and I<br>e of Death  |  | ene 0 0 (                                | 22864  |
|--|---------------------|--|--|--|--|--|
| n 1  | e.                  | 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month                      | Day Yea                                  | 3. Time of Death   |
| Physici<br>/Medic  |                     | Leon Edward Dorsey, Sr.  |  | JULY   | 18 2000                                  |  |
| Examin   |                     |  | Town, or Location of Deatl   | h  | 4c. County of De                         | eath   |
|  |                     |  | ALTI MORE  1 Year   If Under 24 Hrs.                                   | 9 Date of Birth                                | 0.5                                      | tirthology (State or Foreig                                      |
| - Funeral<br>Director  |                     | 212-26-3376 X Months   | Days Hours Min.  | 8. Date of Birth<br>(Month, Day, )<br>Oct. 28, | Yea()928                                 | linthplace (State or Foreig<br>Country)<br>MD                    |
| and  |                     | Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location   |  |  |  | 10d. Inside City Limits  |
| death with the Maryland<br>ms 23a or 28a-f ehow<br>furst be notified at  | ğ                   | MD Baltimore Catonsville   |  |  |  | 1 ☐ Yes 2X No  |
| r 28a  | irec                | 10e. Street and Number 10f. Zip  | Code   | 10   | g. Citizen of What                       | Country?   |
| th with  | aiD                 | 31 Garnet Avenue   | 21228  |  | US                                       | SA   |
| or its   | by Funeral Director | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces? 1 Yes, Specific Fee, Specific F | dent of Hispanic Origin? (Softy Cuban, Mexican, Puerl<br>2 No Specify: | pecify Yes or No-<br>to Rican, etc.)           | 14. Race - Ar<br>Black, Wi<br>Specify: B |  |
| 72 hours<br>natural;   | Completed           | 15. Decedent's Education 16a. Decedent's Usus (Specify only highest grade completed) (Give kind of wo  | al Occupation  | rkına  | 6b. Kind of Busine:                      | ss/Industry  |
| thin the   | nple                | Elementary/Secondary (0-12) College (1-4or 5+)   | rk done during most of worse retired)                                  |  | 0.1.1                                    | D 1  |
|  | Co                  | 12   | ustodian   | ma (First Middle M                             | School                                   | Board  |
| - 0 m 0  | Be                  | 17. Father's Name (First, Middle, Last)  |  | me (First, Middle, Ma                          | alden Sumame)                            |  |
| 2 should be and Mental Is marked (   | 10                  | Carlton Dorsey  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address   | Jeanet<br>(Street and Number or Ru                                     | te Parker                                      | City or Town. State                      | Zin Codel  |
| ind 2 should be file the and Mental Hy 27 is marked oth treumatic event  |                     |  | Ave., Caton  |  |  |  |
| permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke eny injury or other treumatic page.   |                     | 20a. Method of Disposition  1 Burial 2 TCremation 3 Removal from State 4 Donation 5 Other (Specify)  | ne of<br>other place)  | Date 2   | oc. Location - City $ykesvill\epsilon$   |  |
| permit. I<br>Departm<br>Importe<br>eny inju  |                     |  | nd Address of Facility<br>I FUNERAL HO<br>ville, MD 21                 | ME & CHAP<br>784 (410)                         | EL (Box 1<br>-795-1400                   | .95)   |
| Physician //Medical Examiner  per and physician and physic | i Examiner          | 23a. Part1. Enter the disease, or complications (hat caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):   |  | o or respiratory arres                         |  | Approximate Interval Between Onset and Death DAY \$\mathcal{L}\$ |
| ohys<br>the  | dicai               | d.   |  |  |  | 1  |
| death certifi<br>e attending<br>d for use as   | by Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   |  |  | 23d. Date of o                           | delivery<br>Day Year   |
| uires that the nigned by the   | d by Pł             | Part II. Other significant conditions contributing to death but not resulting in the underlying of   | ause given in Part I.  |  |  | to the cause of death?  Probably 4 🗹 nknow                       |
| DIVISION OF VITAL RECORDS, to a Attending Physicien: The law requirest effer cleath.  Director: After this certificate has been signed in by the funeral director, page 2 should be  | Completed           |  |  | 24a. Was an autopsy perform                    | ed2 prior t                              | autopsy findings available o completion of cause of ?            |
| VITA itcian: cartific rector,  | Be                  | 25. Was case referred to medical examiner?   | 26. Place of De  | ath (Check only one                            | 1  |  |
| Physic<br>this ca  | ု                   | 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DC  |  | Home 5 Residen                                 |  | pecify)  |
| VISION OF VITAL Attending Physicien: or death. ector: After this certification the funeral director, in  | Certification:      | 2 Accident investigation M   | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No                                    | 28d. Describe hov                              |  |  |
| To the Hospitel or Attendi<br>within 24 hours after death.<br>To the Funerel Director: A<br>completely filled in by the it   | Certifi             | 4 Homicide determined 28e. Place of Injury - At nome, farm, street, factor building, etc. (Specify)  |  | City or Town,                                  | State)                                   | Rural Route Number,  |
| Lothe Hospitel within 24 hours of the Funerel completely filled  | Medical             | 29a. Certifier  (Check only one)  1 Cretifying Physician: To the best of my knowledge, death occurred 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.  |  |  |  |  |
| To the within 2 To the comple  | Σ                   | 29b. Signature and title of certifier  Purnam, MD  | c. License number P19925   | 29   | d. Date signed (Mo                       | onth, Day, Year)<br>3,2006                                       |
| h  |                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  TYOTHI PUNNAM, 900 S. CATON AVENUE   | /  | RE, MD   | 21229                                    | )  |
| St<br>Regist   | te<br>rar           | 31. Date filed (Month, Day, Year)  32. Registrar's Signature   | ,  |  |  |  |
| DHMH 17 Rev 1/2  | 001                 | The second secon |  |  | ····                                     |  |

DHMH 17 Rev 1/2001

ORIGINAL

|  |                            | 1                   | For<br>State<br>Registrar  | State o   | f Marylar  |  | artment of H   |   | Mental Hyg                             | iene<br>g. No.   | 06                                 | 22865  |
|--|----------------------------|---------------------|--|---|--|--|--|---|--|------------------|------------------------------------|--|
|  | ysicia<br>ledic            | n                   | 1. Decedent's Name (First, Middle, Last<br>Elizabeth   | )   |  | Di                                     | amond  |   | 2. Date of Deat<br>Month<br>July       |                  | )06°                               | 3. Time of Death 1:16AM M                              |
|  | amine                      | er '                | Aa. Facility Name (If not institution, give<br>Gilchrist Center  | <b>1</b>  |  |  | 4b. City, Town, or Tows  | son   |  | 4c. County       | Balt                               | imore  |
| Fund<br>Direc  |                            |                     |  | × <b>ХХ</b> F   | 7. Age (In yrs. 74   | last birthday)<br>Yrs.                 | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs<br>Hours Min                        |  | 27, 1931         | 9. Birthp<br>Cour<br>New           | place (State or Foreign<br>http://<br>York             |
| Maryland   | lied at                    |                     | Usual Residence of Decedent  10a. State 10b. County  1aryland Baltimon   | ~e  |  | ty, Town or Lo                         |  |   |  | <u> </u>         | 1                                  | 1 ☐ Yes 2 ☐ W  |
| th with the  | to ad ter                  | ai Direc            | 10e. Street and Number<br>108 Murdock Road   |   |  |  | 10f. Zip Code  | 21212   | 1                                      | 0g. Citizen of V |                                    | ntry?  |
| 72 hours after death with the Maryland natural, or Iteme 23e or 28e-1 ehow   | xaminerma                  | by Funeral Director | 11. Marital Status  XX Never Married 2 Married 3 Widowed 4 Divorced  | 12. Was Dec<br>Armed Fo<br>1 ☐ Yes<br>If Yes, Gi<br>Year or D | <b>À</b> ØNo<br>ve   |  | Was Decedent of H<br>f Yes, specify Cuba<br>I□Yes ※ No           | ispanic Origin? (S<br>in, Mexican, Puer<br>Specify: | Specify Yes or No-<br>rto Rican, etc.) |                  | k, White,                          | ean Indian,<br>etc.<br>White                           |
| III. C. I.C. 13-0000<br>be filed within 72 hours after death with the Marylan<br>tal Hygiene.<br>Id other than "natural", or Iteme 23a or 28a-f ehow   | he Medical E               | Completed           | 15. Decedent's Edi<br>(Specify only highest grad<br>Elementary/Secondary (0-12)  | cation  |  | (Give                                  | dent's Usual Occup<br>kind of work done of<br>DO NOT use retired | during most of wo                                   | orking                                 | 16b. Kind of Bu  |                                    | dustry   |
| yland a<br>buid be filed<br>Mental Hygis   | tic event, I               | 0                   | 17. Father's Name (First, Middle, Last)<br>Nigel Henry Diamond   |   |  |  |  |   | me (First, Middle, I<br>beth Staf      | Maiden Sumam     |                                    | 011001   |
| 1 and 2 should<br>Health and Men<br>tem 27 le marke  | other treumatic            |                     | 19a. Informant's Name/Relationship (T) Robert Stafford D:  |   |  | new 9                                  | 6 Mill Ro  |   | ford Verm                              | ont 053          | 52                                 |  |
| parification of the property of the property of the part of the pa | any injury or oth<br>once. |                     | 20a. Method of Disposition    Burial X X Cremation 3   I   |   | State  | cemetery, cren<br>eenMoun              |  | ory 7/1<br>ss of FacilityMi                         | 9/06                                   | edefeld          | re,<br>Fun                         | Maryland<br>eral nome                                  |
| ate hys  | the burial-transit         | dicai Exa           | 23a. Pant1. Enter the disease, or simp shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death)  Souther list or cliture if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | abDue to  | (or as a consection as a conse | quence of):                            | er the mode of dyin  |   | c or respiratory arm                   |                  |                                    | Approximate Interval Between Onset and Death Ment      |
| at the death certific<br>by the attending p  | ched for use a             | Physician/Me        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 1 Live  | tcome of pregn<br>birth 2 Feta<br>nant at time of c  | aldeath 3 ☐                            | Ectopic pregnancy<br>Other (specify)                             |   |  | 23d. Dat<br>Moi  | e of delive                        | ery<br>Day Year  |
| quires that I  | eq p                       | leted by Ph         | Part II. Other significant conditions co   | ntributing to c   | leath but not res  | sulting in the u                       | nderlying cause giv  | en in Part I.                                       | 23e. Did tot                           |                  |                                    | he cause of death?<br>pably 4 Unknown                  |
|  | tor, page 2 shoul          | Comp                |  |   |  |  | S  |   | 24a. Was a autops perform              | No 1             | Were auto<br>prior to co<br>leath? | psy findings available<br>mpletion of cause of<br>2 No |
| - O O  | neral direc                | ation: To Be        | 25. Was case referred to medical examiner?  1  Yes 2 No  27. Manne of Death 1  Natural 5  Pending 2  Accident investigation  | 28a. Date   |  | ER/Outpatien<br>28b. Time of<br>Injury | 28c. Injur<br>Wor  | er: 4 🗌 Nursing                                     | Home 5 Reside                          | ence 6 Tothe     |                                    | nttospice  |
| DIVISION  Ne Hospital or Attending  N 24 hours after death.  | ad in by th                | Certification:      | 3 Suicide 6 Could not be determined  | 28e. Plac<br>build  | e of Injury - At h<br>ling, etc. (Speci  | iome, farm, str                        | eet, factory, office   |   | 28f. Location (St<br>City or Town      |                  | er or Rura                         | al Route Number,                                       |
| the Hospital<br>in 24 hours a  | ely fiil                   | edicai              | (Check only 2 Medical Exem   | iner: On the b  | e best of my knoasls of examination of examinations of examinations of examinations of the examination of the examinati | owledge, deatl<br>ation and/or in      | vestigation, in my o   | pinion, death occ                                   |  | ate and place, a | and due to                         | the cause(s)   |
| To the within 2  | шоо                        | Σ                   | 29b. Signature and the of certifier  | y Le  | ly.  | no                                     | 29c. Licens  |   |  | 9d. Date signed  |                                    |  |
| 13   | 7                          |                     | 30. Name and address of person who o   | G   | 3mc  | 670                                    | Print)   | Charl   | es St. 1                               | salts.           | mo                                 | 2006   |
| Re   | Sta<br>gistr               |                     | 31. Date filed (Month, Day, Year)  | 106 32.1  | Registrar's Sign   | ature                                  | and)   |   |  |                  |                                    |  |

06-05125 Devin Duppins

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

|   |   | 1- For State<br>Registrar  | Certificate   | e of Death  | Reg. No.   | 2006 2286  |
|---|---|--|---|---|--|--|
| Physicia<br>ledical Exami   |   | 1. Decedent's Name (First, Middle,Last)  Devin   | uppins  |   | 2. Date of Death  Month Day  July 17, 2006   | Year 3. Time of Death 0630 hrs   |
|   |   | 4a Facility Name (if not institution, give street 2746 North Longwood Street   | et and number)  | 4b. City, Town, or Location of Deat Baltimore City  | h 4c. C  | ounty of Death   |
| Funeral<br>Director   |   | 5. Social Security Number 6. Sex 1 1 1 1 M   | 7 Age (In yrs. last birthda   | yrs. If Under 1 Year If Under 24Hr Months Days Hours Min  | (  | 9/YYYY) 9/ Birthplace (State or Foreign Country)   |
| Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.                             | To Be Completed by Funeral Director       | Usual Residence of Decedent  10a. State  10b. County  10e. Street and Number  11. Marital Status  1 Never Married  2 Married  3 Widowed  4 Divorced If Yes or Divorced of Divo | Was Decedent Ever in U.S  Armed Forces?  Yes 2 No Give Year  ates:  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+) | 10f. Zip Code  21216  3. Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerton Present Street and Number of Street and Number of Company of Street and Number of Company of Street and Number of Company of Street and Number of Company of Street and Number of Company of Street and Number of Company of Street and Number of Company of Street and Number of Company of Street and Number of Company of Street and Number of Company of Street and Number of | Specify Yes or No- o Rican, etc.)  work done tired)  le (First, Middle, Maiden Su  Rural Route Number, City of Date  21/2006  Lace   | 10d Inside City Limits 1 X Yes 2 No n of What Country?  USA Race - American Indian, Black, White, etc.  Decify: Black d of Business/Industry  Hy Of Balto.  Imame)  Sor Town, State, Zip Code)  21 Ho Md. 21216  Cation - City or Town, State  15 Sowne, Md. |
| Physician /Medical  | ner                                       | or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to be  | ons the clused the death. Do not en   | nter the mode of dying, such as cardiac   | uneral Home. Balto, Mc<br>or respiratory arrest, shock,  | or heart Approximate Interval Between Onset and Death  |
| O. Box 68760, hat the death certificate be executed ed by the attending physician and letached for use as the burial - transit  | Physiciar                                 | d.  X UNPENDED AM  IF FEMALE: 23   | c. If yes, outcome of pregnancy Live birth 2 Pregnant at time of death 5 Unknown  | Ba-f, perME, g859, 9/27/06  Fetal death 3 Ectopic pregr Other (Specify)  the underlying cause given in Part I.  | nancy 23d Did tobacco use  | Date of delivery onth Day Year e contribute to the cause of death?   |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring | Medical Certification: To Be Completed by | 1 Natural 5 Pending 2 Accident Investigation 3 X Suicide 6 Could not be determined 4 Homicide 29a. Certifier (Check only one) 2 Medical Examiner: On the determined  | 28a. Date of Injury 28b. Tim (Month, Day, Year)  Fnd 7/17/2006 FNd 6 28e. Place of Injury - At home, farm (Specify) residence  To the best of my knowledge, death   | 28c. Injury at Work?  1 Yes 2 No  | 24a Was an autopsy performed?  1  Yes 2 No  conly one)  ing Home 5 Residence  28d. Describe how injury  Subject shot:  28f. Location (Street and or Town, State) 274  Limore, MD  id due to the cause(s) and not the time, date and place. | self Number of Rural Route Number, City 46 N. Longwood Street nanner as started.   |
| S<br>Regis  | tate<br>trar                              | 31. Date filed (Month, Day, Year)  | t Medical Examiner 111  32. Redistràr's Signature   | Penn Street, Baltimore, MD 2  | 1201   |  |

State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 07/16/2006 2:30 a M **Physician** Nellie G. Devaney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore St. Elizabeth Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days **Funeral** Hours 1□M 3/□F Director 06/07/1920 212-22-6466 Usual Residence of Decedent Ireland 10d. Inside City Limits with the Maryland 10a State 10b. County 10c. City, Town or Location 27 Is marked other than "natural", or itema 23a or 28a-1 show traumatic event, the Madical Examinar must be retified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3320 Benson Avenue 21227 United States death Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural, or Item any injury or other traumatic event, the Mudical Exemina 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Marker Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Penelope Nolan ဥ Patrick Devanev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret B. O'Connell (Niece) 10 Kings Glen Court, Kingsville, MD. 21087 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 □Other (Specify) New Cathedral Cemetery 07/19/06 Baltimore, Maryland 22. Name and Address of Facility 21. Signaturi of Furt rvice Licensee Hubbard Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approxim Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) das **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physiclen and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 ☐ Other (specify) å. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 No Attending Physician: 25. Was case referred to medical 26. Place of Death Check only one Be examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ျှ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1\_Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident affer death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier (Type, Print) US2746 mily, 18, 2006 Westoden Chair lane Galf 21228 30. Name and address of person completed cause of death (Item 23a) (Type, Print) brill 720 YPILAR 31. Date filed (Month, Day, Y r) DEUS Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 📙 📗 🦙 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 07/19/2006 Year Anthony Diangelo 12:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5214 Wilkens Avenue Catonsville Baltimore County Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1**2** M 2 □ F 81 220-14-0867 06/13/1925 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore County Catonsville Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5214 Wilkens Avenue 21228 United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I SYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White Ď 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plmber Owner/Plumbing Busines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Umbreta Diangelo ပ Irene Pilli 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret P. Diangelo (Wife)
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hills Cemetery 07/22/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Cancer-Liver Mets Sopha Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2□ No 1 Yes 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one

Physician /Medical Examiner

**Funeral** 

Director

r then "naturel", or itema 23a or 28a-f ehow the Medical Examinar must be notified at

other then

ie marked

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked soy injury or other traumatic evone.

2 should be f and Mental H

within 72 hours after death

Maryland 21215-0036

Baltimore,

Ö

Division of Vital Records,

attending physicien and for use as the burial-transit The law requires that the death certificate be executed signed by the a Id be detached f

should ! has certificate funeral death. Director:

٩

Certification:

Medical

filled in by

within 24 hours a To the Funerei I

State

29b. Signature and title of certifier ottendine marke

MO

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D20393

Other: 4 Nursing Home

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

me esidence 6 Other (Specify)
28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 22a) (Type, Print)

2006

Hospital:

28a. Date of Injury (Month, Day Year)

and manner stated.

Ternendez 31. Date filed (Month, Day, Year)

5 Pending

investigation

6 Could not be determined

2

1 🗌 Yes

Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 T Homicide

32. Resistrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient

28b. Time of

405 Fredorice Rd Ste 162 Cetoninlle

3 DOA

28c. Injury at Work?

Contrying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For Stete Registrar 1-Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 4.50 AM /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner ITIMOre 710 8. Date of Birth Month, Day Birthplace (State or Foreign Country) 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 12 M 2 F 220-40-7555 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other traumatic event, If a Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9 Нета 23а Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubas, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 2 No ō 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White Year or Dates: 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry ie marked other then Elementary/Secondary (0-12) College (1-4or 5+) 18. Mothers Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental h permit. Pages 1 and 2 should be Deportment of Health and Menta Important: if item 27 is marked eny injury or other traumatic evone. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informa t's Name/Relationship (Type, Print) 21200se crtsuille, mr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State tallstor 20106 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licer as Funeral chapel-BelAir 21050 mo complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, brity one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure Immediate Cause (Final) ears Cancer Physician disease or condition resulting in death) /Medical Dul to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner hed by the ettending physicien and a detached for use es the burial-transmit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by cete has been signe, page 2 should be u 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has this certificete After this certifice funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Stother (Specify) NOSPLU 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Injury 1) Natural 5 Pending death. 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

within 24 hours efter death To the Funeral Director: , completely filled in by the f

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D58303

Manuno no 2/204

Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

51

29d. Date signed (Month, Day, Year) 18 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMON CHAMES MY GGO! IV CLINGS

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only one)

32 Registrar's Signature

h

State Registrar

State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20,2006  $\operatorname{July}^{\scriptscriptstyle\mathsf{Month}}$ **Physician** 8:08 A M Louise Epstein Marietta /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Cockeysville Broadmead If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) **Funeral** Months Days Hours Min 1 ☐ M 21分F 213-22-4977 79 30,1926 Indiana Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show r iteme 23a or 28a-f shov iner must be notified at 1 ☐ Yes 2 ☑ No Directo Cockeysville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21030 13801 York Rd, Q11 by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ▼No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3¥ Widowed 4 □ Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry itte Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 ie marked other than 1, any jury or other traumatic event, the Mag 9068. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marietta Billie Harry Tillman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 843 West University Parkway Balto, MD 21210 Daniel M. Epstein/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 7/21/06 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 6000 23a. Part 1. Enter the disease, or complical, ns that sised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one card on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed Due to (or as a consequence of): the attending physician ned for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use coptribute to the cause of death? Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 17 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 ☐ Yes 2 ☐ No 2 No 1 Yes certificate 25. Was case referred examiner? 26. Place of Death Check only one funeral director, Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗆 Yes 3 DOA 2 No 1 Inpatient 2 ER/Outpatient Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deall

To the Funeral Director:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

or 28e-f show

or Items 23a

Is marked other than

1 and 2 should be Health and Mental

other traumatic event, the Medical Examiner must be notified at

The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Division of Vital Records, P.O. Box 68760 be detached To the Hospital or Attending Physician:

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Willie R. Everett JULY 09, 2006 05:18A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 26, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ₹M 2 □ F 78 424-24-7335 Alabama Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4506 Mary Avenue 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊕ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: δ black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk unk 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Everett Carrie Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health an.
Important: If item 77 Is m.
any injury or other: Carrie Everett/daughter 450 Mary Avenue Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State `4 □Donation 5 ☑ Other (Specify) in state 21. Signature of Funeral Service Licensee Rould, S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director 21201 nzz Baltimore, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCER UNKNOWN Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number VA01010580281 JULY 9,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902 JIANYI ZHANG, M.D., 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

within 24 hours a To the Funeral L

State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** MAG 2006 /Medical 4a. Fecility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MERCY MEDICH 5. Social Security Number (INV 6. Sex 1XM 2DF BALTIMORE If Under 24 Hrs. CITY MEDICAL Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** MAY 14, 2006 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "naturel", or Itema 23a or 28a-f show eny injury or other traumatic avent, Ite Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rei', or itema 23a or 28a-f show Examiner must be notified at BALTIMORE 1 Yes 2 □ No Be Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? USA ORTAGE AVE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MASHAWN KENT DELAYCA ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PORTAGE AUE DELAYCA EVANS BALTIMORE MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ATHUDRA Bactimore mD. 21. Signature of Funeral Service Ligense 22. Name and Address of Facility 2134 Willow Spring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EXTREME PREMATURIT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence off sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 😿 No Division of Vital 1 ☐ Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 2 Medical Exe 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) JEAN MD 301 PAUL PLACE BALTIMORE MD 57 32. Registrar's Signature 31. Date filed (Month Day Year) State 2006 2 Registrar

|          |  |                  | For State Registrar   |                    | of Maryla                                 |              | Depa                        | ırtme                            |  | ealth a                  |              | The state of the s |            | _            | 06                    | 228                                 | 373               |
|----------|--|------------------|---|--------------------|---|--------------|-----------------------------|----------------------------------|--|--------------------------|--------------|--|------------|--------------|-----------------------|-------------------------------------|-------------------|
|          | Dhuaiai  |                  | 1. Decedent's Name (First, Middle   | , Last)            | <u>.</u>                                  |              |                             | 1                                | <u>-</u>                                 |                          |              | 2. Date of De<br>Month   | ath<br>Day |              | Yeag                  | 3. Time of                          |                   |
|          | Physicia<br>/Medic   |                  | AILEEN  | 13_                |   | +            | 10                          | -                                |  |                          |              | JULY   | 187        |              | 006                   | 0200                                | Ам                |
|          | Examin   | er               | 4a. Facility Name (If not institution,  | _                  |   | 60           |                             |                                  |  | Location of              |              |  | 4c.        |              | of Death              |                                     |                   |
|          |  |                  | Johns Hopkins 5. Social Security Number                                       | BAMIKA<br>6. Sex   | 7. Age (In yrs                            |              |                             |                                  | or 1 Year                                | If Under 2               | 24 Hrs.      | 8. Date of Bir   | th         |              | V/A<br>9 Birth        | niace (State n                      | r Foreian         |
|          | Funeral Director   |                  | 219-18-9716   | 1 □ M 2 X F        |   |              | Yrs.                        | Months                           |  | Hours                    | Min.         | (Month, Da   | y, Year)   | 926          | Cou                   | piace (State of<br>ntry)<br>Marylai | nd                |
|          | 2  |                  | Usual Residence of Decedent   |                    | 140.0                                     |              |                             |                                  |  |                          |              |  |            |              |                       |                                     |                   |
| -        | show<br>show   | 7                | 10a. State 10b. County  |                    | 100.0                                     | ity, Tow     | n or Lo                     |                                  |  |                          |              |  |            |              |                       | 10d. Inside Cit<br>1                |                   |
|          | 28a-f  | ecto             | Maryland N  10e. Street and Number  | /A                 |   |              |                             |                                  | <u>timor</u><br>ip Code                  | e                        |              |  | 10a Citi   | zen of V     | What Cou              |                                     |                   |
| 3        | death with the maryland<br>ms 23s or 28s-f show<br>r must be foldfied at   | Funeral Director | 4905 East Chas  | o Stroo            | +   |              |                             | 101.2                            | •  | 205                      |              |  |            |              | S. ,                  |                                     |                   |
|          | ms 2:  | Jera             | 11. Marital Status  | 12. Was D          | ecedent Ever in Forces?                   | U.S.         | 13. \                       | Vas Dec                          |  |                          | jin? (Spe    | crfy Yes or No<br>Rican, etc.)   | )^         | 14. Rac      | e - Ameri             | can Indian,                         |                   |
| 0        | or its   |                  | 1 Never Married 2 Marri   |                    | s 2 No<br>Give                            |              |                             |                                  |  | Specify:                 | , ruerto r   | rican, etc.)   |            | Specify      | ck, White             | , etc.                              |                   |
| 500      | within 7 z nouts allet deam with the marylar ene of their their calural; or Itama 23a or 28a-1 show the Medical Exactions must be solitized at | d by             | 3 XWidowed 4 □ Divorced   | Year o             | r Dates:                                  | 1            |                             | _                                |  |                          |              |  |            |              | wn                    | ite                                 |                   |
| ה<br>ה   | n /2 n   | Completed        | 15. Decedent<br>(Specify only highes  | t grade complete   |   | 16a          | . Deced<br>(Give<br>lite. L | lent's Us<br>kind of w<br>DO NOT | ual Occupa<br>ork done d<br>use retiredi | ition<br>uring most<br>I | of workir    | ng   | 16b. K     | nd of Bu     | ısinəss/lı            | ndustry                             |                   |
| 7        | then.  | dwo              | Elementary/Secondary (0-12)   |                    | e (1-40r 5+)<br>2 <i>US</i>               |              |                             |                                  |  | Office                   |              |  |            | Ва           | nkin                  | g Compa                             | เทน               |
| and      | be filed with<br>tal Hygiene.<br>d other ther<br>svant, the M  | BeC              | 17. Father's Name (First, Middle, I   |                    |   |              |                             | 1                                |  |                          |              | (First, Middle   | , Maiden   |              |                       |                                     |                   |
| /ar      |  | To B             | Robert Fogler   |                    |   |              |                             |                                  |  | Sa                       | arah         | Heckro   | te         |              |                       |                                     |                   |
| lar)     | s 1 and 2 should<br>f Heelth and Mer<br>item 27 is marke<br>other traumatic  |                  | 19a. Informant's Name/Relationsh  | 760                |   | 195          |                             | -                                |  |                          |              | Route Numb   |            |              |                       |                                     |                   |
| ≥ :      | leelth<br>m 27<br>hertr  |                  | Michael J. Fick   | ., Sr. (           | Grands on                                 | 34           | 10 S                        | outh                             | Maca                                     | on St.                   |              | ultimo)<br>ato   |            |              |                       | 21224<br>own, State                 |                   |
|          | 8°= 5  |                  | 20a. Method of Disposition 1   Burial 2 □ Cremation                           |                    | m state                                   |              |                             |                                  | ame of<br>other place                    | 1                        |              |  |            |              |                       |                                     | 0 1               |
| Saitimo  | rtant:   |                  | 4 Donation 5 Other (S) 21. Signature of Funeral Service I                     |                    | Gl  | en i         |                             |                                  |  |                          |              |  |            |              |                       | , Mary                              | Land              |
| g        | permit. Departm Importa sny inju   |                  | Butter  | . 110              | 0   |              |                             |                                  |  |                          |              | imunek<br>satim  |            |              |                       |                                     |                   |
|          |  |                  | 23a. Part1. Enter the disease, or   | complications that | at caused the dea                         | ath. Do      |                             | A Report Company of the Paris    |  |                          | -            |  |            | IVICE •      | 212                   | Approximate                         | •                 |
| F        | hysician   |                  | shock, or heart failure. List   |                    | EREBI                                     | D A 1        |                             | TIL                              | FAD                                      | CTIC                     | () k /       |  |            |              | 4                     | Onset and                           |                   |
|          | /Medical   |                  | disease or condition resulting in death)                                      |                    | to (or as a conse                         |              |                             | - /                              | 1110                                     | .0110                    | <i>-</i> ) ( |  |            |              |                       | 1-500                               | 45                |
| ľ        | Examiner   | _                | Sequentially list conditions,   | b                  |   |              |                             |                                  |  |                          |              |  |            |              |                       |                                     |                   |
| -        | ed sit   | Examiner         | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due                | to (or as a conse                         | eque ice     | ol).                        |                                  |  |                          |              |  |            |              |                       |                                     |                   |
|          | be executed<br>icien and<br>burial-transit   | xan              | that initiated events resulting in death) Last                                | c. Due             | to (or as a conse                         | quence       | of):                        |                                  |  |                          |              |  |            | -            | -                     |                                     |                   |
| -        | 0 9 0  | calE             |   | d.                 |   |              |                             |                                  |  |                          |              |  |            |              |                       |                                     |                   |
| 9        | cermicat<br>nding phy<br>use as th   |                  |   |                    |   |              |                             |                                  |  |                          |              |  |            |              |                       | .0:<br>                             |                   |
| Š        | tendir<br>tendir<br>r use  | an/h             | IF FEMALE:<br>23b. Was decedent pregnant                                      |                    | outcome of preg                           |              | 3 🗆                         | Ectopic                          | pregnancy                                |                          |              |  | 1          | 23d. Dai     | te of deliv           | •                                   | 'ear              |
| 5        | the death<br>by the etter<br>ached for u   | sici             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                       |                    | egnant at time of<br>iknown               | death        | 5                           | Other (                          | specify)                                 |                          |              |  |            | MO           | (ILII)                | Day Y                               | ear               |
| Z.       | w requires that the de<br>been signed by the<br>should be detached   | by Physician/Med | Part II. Other significant condition  | ns contributing to | o death but not re                        | sultina i    | n the u                     | nderlvina                        | cause give                               | n in Part I.             |              | 23e. Did   | tobacco u  | se cont      | ribute to             | the cause of de                     | eath?             |
| g,       | law requires mar<br>as been signed b<br>2 should be dete   |                  | •   | <b>3</b>           |   | •            |                             | ,                                | •  |                          |              | 10   | Yes 2      | □No          | 3 ☐ Pro               | bably 4                             | Inknown           |
| ecords   | w req  | lete             |   |                    |   |              |                             |                                  |  |                          |              | 24a. Was   | an         | 24b. \       | Were aut              | opsy findings a                     | avallable         |
| ř,       | the lay  | ompleted         |   |                    |   |              |                             |                                  |  |                          |              |  | rmed?      |              | prior to co<br>death? | 2 No                                | use of            |
|          |  | 3e C             | 25. Was case referred to medical  |                    |   |              |                             |                                  |  | 26. Place                | of Death     | Check only   | No<br>one  |              | 103                   | ZIEJ NQ                             |                   |
| > i      | D 2. ≺   | To B             | examiner?   | Hospital:          | Inpatient 2                               | ERVO         | utpatien                    | t 3 🗆 C                          | Othe Othe                                | <sup>)r:</sup> 4 🗆 Nuı   | rsing Hon    | ne 5∐Res   | dence      | 5 □Oth       | er (Speci             | fy)                                 |                   |
|          | ding Ph<br>h.<br>After th<br>funeral   |                  | 27. Manner of Death  1 Natural 5 ☐ Pending                                    | g (N               | ite of Injury<br>fonth, Day Year)         |              | Time of<br>Injury           |                                  | 28c. Injury<br>Work                      |                          | 1            | 8d. Describe   | how inju   | y occurr     | red                   |                                     |                   |
| <u>0</u> | death.<br>ctor: A<br>y the fu  | cat              | 2 Accident investig   | ot be              | non of Injury. At                         | bone (       |                             | M                                |  | /es 2□N                  |              | 196 Location   | Ctroot or  | al Alexandra |                       | of Davids Mills                     |                   |
|          | 5 4 4 5  | Certification;   | 4  Homicide determ  | ined 289. Pi       | ace of Injury - At<br>illding, etc. (Spec | cify)        | arm, str                    | eet, racto                       | гу, опісе                                |                          | 1            | City or To   |            |              | er or mur             | al Route Numi                       | ) <del>0</del> 1, |
|          | Hospital or<br>14 hours afte<br>Funeral Dir<br>tely filled in  |                  | 29a. Certifier 1 Certifyin  | g Physicien: To    | the best of my ki                         | nowledg      | e, death                    | occurre                          | d at the tim                             | e, date and              | d place, a   | and due to the   | cause(s)   | and ma       | nner as :             | stated.                             |                   |
|          | n 24 h   | Medical          | (Check only 2 Medical l   | examiner: On the   | e basis of examinancer stated.            | nation ar    | nd/or in                    | estigatio                        | n, in my op                              | inion, deat              | th occurre   | ed at the time,  | date and   | place,       | and due               | to the cause(s)                     | 1                 |
|          | To the Hospital within 24 hours a To the Funeral C completely filled   | Σ                | 29b. Signature and the of certifier   | -75                | 1. 12                                     |              |                             |                                  | 9c. License                              |                          |              |  |            |              |                       | Day, Year)                          |                   |
|          | 1  |                  | 10/2/2  | -000               | MO TH                                     | b            | 0772                        | . Data                           | RES                                      | -0                       | 00           |  | JUL        | 4 1          | 8 74                  | , 2000                              | 9                 |
| 5        | ,  |                  | 30. Name and address of person  | who completed c    | ause of death (Ite                        | em 23a)      | (Type,                      | Print)                           |  | Λ.                       |              | . 0  |            | 0/           | 114-5                 | , 2000<br>NAM) ZI                   | n= //             |
|          | Sta  | to               | 31. Date filed (Month, Day, Year)   | 32                 | Registrar's Sign                          | 77<br>nature | 70                          | CA                               | 216/2                                    | N AL                     | 14NL         | r, DAC   | 1/10/      | 4            | MUZ                   | ivvi) Zi                            | 47                |
| Talki.   | Registr  |                  |   | 2006               | Chicken A                                 | di.          | 100                         | ner                              |  |                          |              |  |            |              |                       |                                     |                   |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#5, perFH, 9857, 7/21/06 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Үөаг **Physician** BERTRAND FINK 09:38 PM 20 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Sinau Baltimore baltinose City N/A If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Becurity Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2□ F Days <del>335</del>-30-6679 Yrs. 72 Director 05/20/1934 OIHO Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 27 is marked other than "natural", or Items 23s or 28s-f show traumatic event, the Modical Experiment must be notified at MD N/A BALTIMORE 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3501 LABYRINTH ROAD 21215 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Spacify 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within 7 if Health and Mental Hygiene. Item 27 Is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) RABBI EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MORTON FINK SYLVIA GRUNSTEIN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUISE FINK / WIFE 3501 LABYRINTH ROAD - BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of important: If It any injury or o once. 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ERETZ HA CHAIM 07/23/2006 BET SHEMESH, ISRAEL 21. Signatur of Funeral Service L 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part . Enter the disease, or shock, or leart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Chronic /Medical Due to (or as a consequence of) Examiner Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 \(\subseteq\text{ Yes} \quad 2 \subseteq\text{ No}\) 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, s been signed should be c Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No autopsy performed? 1 Yes 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 S Natural death. 1 Yes 2 No 2 Accident the hours after deat 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the h 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) KES-000 Haaswa address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Bertrand

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🛭 🗍 State RegistranMEND #8 PER and bd g857 7/2140 tifinate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FISHER Month **Physician** KOBERT 6:40 AM 06 5 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and nymber) 4c. County of Death Examiner GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S 8. Date of Birth 1935 (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex Birthplace (State or Foreign Country) Hours 1 X M 2□F 164-30-5190 70 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits GEORGES MD PRINCE 1 XYes 2 □ No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9586 MURKIRK UJA Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: item 27 is marked other than "natural", or iteme other traumatic event, the Medical Examination 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN UNKNOWN permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If tem 27 is marked other eny injury or other traumatic event, SAGE. 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame, unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Prince George's Hospital Center 3001 Hospital Drive Cheverly, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🖾 Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to initio date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). use as the burial-transit DNIESTIVE Due to (or as a consequence of): Box 68760, ete has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificete 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4 Heading BACY QM.D. D42580

State Registrar

MRH 1086264

9-18-1935

books

5632 ANNAPOLIS RD #13

BLADENSBURG, MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

AUJLA, MD

31. Date filed (Month, Day, Year)
JUL 2 1 2006

|                     |  | •                 | For<br>State<br>Registrar   | State o  | f Maryland  |                      | artment<br>rtificate                    |                        |               | ind M                                   |   | iene<br>g. No.20          | 06                     | 22876                                      |
|---------------------|--|-------------------|---|--|---|----------------------|---|------------------------|---------------|---|---|---------------------------|------------------------|--|
|                     | Dharatai   |                   | 1. Decedent's Name (First, Middle   |  | ,   |                      |   |                        |               |   | 2. Date of Deat<br>Month                    | h<br>Day                  | Year                   | 3. Time of Death                           |
|                     | Physici<br>/Medic  |                   | Elinor  |  | Fivehous  | e<br>                |   |                        |               |   | July  |                           | 006                    | 11:10 a <sup>M</sup>                       |
| 1                   | Examin   | ier               | 4a. Facility Name (If not institution GREATER BALTI   | MORE MEDIC   | CAL CENTI   |                      | TOWS                                    | ON                     | Location o    |   |   | 4c. County<br>BALT        | IMOR                   | E  |
|                     | Funeral<br>Director  |                   | 5. Social Security Number 157-07-6300   | 6. Sex<br>1 □ M 2 🔀 F                                  | 7. Age (In yrs. la:   | st birthday)<br>Yrs. | If Under<br>Months                      | 1 Year<br>Days         | If Under a    | Min.                                    | 8. Date of Birth<br>(Month, Day,<br>Dec 29, | 1917                      | 9. Birth<br>Cou<br>NEL | place (State or Foreign<br>ntry)<br>Jersey |
|                     | and w  | }                 | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City,  | Town or Lo           | ocation                                 |                        |               |   |   |                           |                        | 10d. Inside City Limits                    |
|                     | Manyl.<br>f sho  | ō                 | MD Ba   | altimore   | Ba  | ltimo                | re                                      |                        |               |   |   |                           |                        | 1 ☐ Yes 2 X No                             |
|                     | 1 the  | Director          | 10e. Street and Number  |  |   |                      | 10f. Zip                                | Code                   |               |   | 1   | 0g. Citizen of V          | /hat Cou               | intry?                                     |
| •                   | h with   | D E               | 8808 Wolvertor  | n Road   |   |                      |   | 2123                   | 4             |   |   | U.S.A                     | •                      |  |
| )                   | deatl  | Funerai           | 11. Marital Status  | 12. Was Dece<br>Armed Fo                               | edent Ever in U.S.  | . 13.                | Was Deced                               | ent of His             | spanic Orig   | in? (Spe                                | ecify Yes or No-<br>Rican, etc.)            |                           | e - Ameri<br>k, White, | can Indian,                                |
| 9                   | or its   | S                 | 1 Never Married 2 Married   | ned 1 ☐ Yes<br>If Yes, Giv                             | 2 <b>⊠</b> No<br>⁄e   |                      | 1 ☐ Yes 2                               |                        | Specify:      | , |   |                           | Whi                    |  |
| 8                   | urai',   | d by              | 3 Widowed 4 Divorced  |  | ates:   | 100 D                |   | 10                     | *:            |   |   |                           |                        |  |
| 215-0036            | within 72 hours after death with the Maryland<br>ene.<br>then "natural", or items 23e or 28e-f show<br>the Medical Examinar must be notified at  | Completed         |   | st grade completed)                                    |   | (Give                | dent's Usua<br>kind of wor<br>DO NOT us | k done d<br>e retired) | uring most    | of worki                                | ng  | 16b. Kind of Bu           | siness/ir              | ndustry                                    |
| 12                  | within<br>then<br>then   | E C               | Elementary/Secondary (0-12)   | College (1   | -4or 5+)  |                      | ctret                                   |                        |               |   |   | Baltim                    | ore                    | Schools                                    |
| D                   | Hygother<br>ent,   | BeC               | 17. Father's Name (First, Middle,   | Last)  |   |                      |   |                        | 18. Mothe     | r's Name                                | (First, Middle, M                           |                           |                        |  |
| a                   | Alenta<br>Alenta<br>rked<br>tic sy   | To B              | Henry   | High   | man   |                      |   |                        | Ma            | ary                                     |   | Hol                       | t                      |  |
| Maryland            | s 1 and 2 should be filed within 72 hours after death with the Marylan if Heelth and Mental Hygiene if Heelth and Mental Hygiene teems 23e or 28e-f show teem 27 is marked other then "natural", or items 23e or 28e-f show other traumatic svant, the Medical Exercities must be notified at  | 4                 | 19a. Informant's Name/Relations   |  |   |                      | •                                       |                        |               |   | Route Number                                |                           |                        | •  |
|                     | eelth<br>m 27<br>her tr  |                   | Herbert J. Fiv  | /ehouse  | 20h Die   |                      |   |                        | n Ka.         |   | altimore<br>Date                            | ·                         | 1234                   |  |
| Ore                 | Pages 1<br>nent of H<br>ant: if ite<br>ary or oth  |                   | 20a. Method of Disposition  1   | 3 Removal from   | State Cer   | netery, cre          | natory or ot                            | her place              | ) 1           |   | 9/06  | 20c. Location -<br>Timoni | -                      |  |
| Baltimore,          | t. Partmen   |                   | 4 □Donation 5 □ Other (S<br>21. Signature of Funeral Septice  |  |   | •                    | Valle                                   | •                      | o of Equility | •                                       |   |                           | -                      | lome, Inc.                                 |
| Bal                 | permit. Pages 1 and 2<br>Depertment of Heelth s<br>Important: If Item 27 li<br>any injury or other tra<br>9066.  |                   | 21. Signature of Funeral Septice  | Cicensee (I) I I I I                                   | all G. Da   |                      |   |                        |               |   | uson, MD                                    |                           |                        | une, The                                   |
| 8760,               | Physician /Medical Examiner pruisition and pruisiti | ical Examiner     | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. — Dua to (  | or as a conseque  | nise of):            | u H                                     | EM                     | ore h         | Agi                                     |   |                           |                        |  |
| P.O. Box 68         | the death certific<br>by the attending p<br>ached for use as   | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 △ No 9 □ Unknown   | 1☐Live b   | come of pregnand<br>irth 2   Fetal d<br>ant at time of dea<br>own | leath 3              | Ectopic pre                             |                        |               |   |   | 23d. Dat<br>Mor           |                        | ery<br>Day Year                            |
| of Vital Records, P | w requires that<br>s been signed b<br>should be deta   | ۵                 | Part II. Other significant condition  | ons contributing to de                                 | Path but not result   | . •                  | nderlying ca                            | ause give              | n in Part I.  |   | 1   |                           | ibute to t<br>3 🗌 Prol | the cause of death?                        |
| 000                 | aw rec<br>s bee  | Completed         | Sein  | copy   |   |                      |   |                        |               |   | 24a. Was a                                  | n 24b. V                  | Vere auto              | opsy findings available                    |
| Re                  | The lav  | E                 | •)  |  |   |                      |   |                        |               |   | autops<br>perform                           | ned? d                    | eath?                  | ompletion of cause of                      |
| ital                | ian:<br>rtifice<br>ctor. p   | Bec               | 25. Was case referred to medica examiner?   |  |   | O_RETEX              | XXXX                                    |                        | 26. Place     | of Death                                | (Check only on                              |                           |                        |  |
| Ž V                 | Physician:<br>rthis certificanal director.   | 卢                 | 1 Yes 2 No  |  |   | R/Outpatier          |   |                        | 4 📙 🕅         |   | ne 5 ☐ Reside                               |                           |                        | fy)  |
| ם                   | ing P  |                   | 27. Manner of Death  1 ✓ Natural 5 ☐ Pendir   | ig .   | of Injury 2<br>th, Day Year)                                      | 8b. Time o<br>Injury |   | Bc. Injury<br>Work     |               |   | 28d. Describe ho                            | w injury occurr           | ed                     |  |
| 2.0                 | Attending<br>r death.<br>ector: After<br>by the fune   | cati              | 2 Accident investi 3 Suicide 6 Could  | not be an Blace  | of laiver. At hom   | o form at            | M A Section                             |                        | ′es 2 🗆 I     |   | ORf Location (St.                           | reat and Number           | or or Pur              | al Route Number.                           |
| Division            | al or Al<br>s efter of<br>th Direct  | Certification;    | 4 ☐ Homicide determ   | 28e. Place<br>buildi                                   | of Injury - At hom<br>ng, etc. (Specify)                          | 10, 141111, 50       | eet, factory,                           | , once                 |               |   | City or Town                                |                           | or nur                 | ar noble Number,                           |
|                     | To the Hospital or Attending Physician: The I within 24 hours eiter death. To the Funers! Director: After this certificete he completely filled in by the funeral director. page   | edical (          |   | ng Physician: To the<br>Examiner: On the ba<br>and man |   |                      |   |                        |               |   |   |                           |                        |  |
|                     | To the within To the Comp  | Me                | 29b. Signature and title of certifie  | - 111 -  |   |                      |   | License                |               |   | 1   | d. Date signed            |                        |  |
|                     | 1  |                   | > VVIONUS   | COLOX  | MI  |                      |   | 1-1                    | 14)0          | 15                                      | (   | 07-16                     | ,-2                    | 006  |
| d                   | 4-1  |                   | 30. Name and address of person  | who completed clus                                     | e of death (Item 2  | 3a) (Type,           | Print)                                  | in                     | aleg          | 5 12                                    | lesso                                       | Reison                    | , sti                  | 21204                                      |
|                     | Sta<br>Registi   |                   | 31. Date filed (Month, Day, Year)   |  | egistrar's Signatu  | re                   | ade                                     |                        |               |   |   |                           |                        |  |

DHMH 17 Rev 1/2001

|                |   |                |  | partment of Health and Mental Hygi<br>Pertificate of Death   | Z H U b Z Z B I I  |
|----------------|---|----------------|--|--|--|
|                | 9   |                | Decedent's Name (First, Middle, Last)  | 2. Date of Death   | _  |
|                | Physicia<br>/Medic  |                | FRANCES FI   | MNAN Month   | Day Dear 8:589 M   |
|                | Examin  | er             | 4a. Facility Name (If not institution, give street and number) Riverview Nursing Center  | 4b. City, Town, or Location of Death  Essex  | 4c. County of Death Baltimore  |
|                | Funeral   | A"             | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday   |  | 9 Birthplace (State or Foreign   |
|                | Director  |                | 213-05-5537 1 M 22 F 94 Yrs. Usual Residence of Decedent   | 9/21/1   | Maryland   |
|                | yland<br>now  |                | 10a. State 10b. County 10c. City, Town or L  | cocation   | 10d. Inside City Limits  |
|                | Ba-fal  | Director       |  | erry Hall  | 1 □ Yes 2 No   |
|                | with the  |                | 10e. Street and Number 21 Beagle Run   | 10f. Zip Code 21236  | g. Citizen of What Country?  |
|                | death<br>ms 23  | Funeral        |  | . Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  | USA<br>14. Race - American Indian,   |
| 98             | or Ite  | y Fur          | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give  | If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1☐ Yes 2☑ No Specify:   | Black, White, etc.   |
| 21215-0036     | within 72 hours after death with the Maryland<br>ene.<br>then "naturel", or Items 23a or 28a-f ahow<br>the Marical Examilier: ust be notified at  | ed by          | 3_Mildowed 4 Divorced Year or Dates:   |  | White 6b. Kind of Business/Industry  |
| 215            | thin 72<br>e.<br>en "ng   | Completed      | (Specify only highest grade completed) (Giv.   | re kind of work done during most of working  | Lord Baltimore   |
| 121            | filed wi<br>Hygien<br>other th  |                | 5 0 In   | ispector 18 Market Nova (571 Market)   | Press  |
| Maryland       | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 Ia marked other then "naturel", or Items 23a or 28a-f ahow any injury or other traumatic event, It's Madical Examinations to other traumatic event. | To Be          | Felix Wieczynski   | 18. Mother's Name (First, Middle, M.  Maryanna Cies  |  |
| ary            | 2 shou<br>and M<br>la mar<br>sumat  | -              |  | ling Address (Street and Number or Rural Route Number,   | <del></del>  |
| e<br>S         | 1 and 2<br>Health<br>Iem 27<br>other tra  |                | Paul C. Wieczynski / Brother 21  20a. Method of Disposition 290. Place of Qisp   |  | Md. 21236  |
| nor            | Pages<br>nent of h<br>ant: If ite<br>ary or of  |                | 1,25 Dunal 2 Cremation 3 Chemical notes 3 tale   | ethac rad diner Oute)  | Oc. Location - City or Town, State  Oundalk, Md.                           |
| Baltimore,     | permit. P<br>Departme<br>Importan<br>any injur  |                |  | emetery †7/20/06 I<br>22 Name and Address of Facility<br>Caczor Owsk facility uneral Hom   |  |
| <u> </u>       | 89 2 8 8  |                | Eugene - Cart ft 1   | 201 Dundalk Ave. Balti   | more, Md. 21222  |
| п              |   |                | 23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. | iter the mode of dying, such as cardiac or respiratory arres   | st, Approximate Interval Between Onset and Death                           |
|                | Physician<br>/Medical   |                | disease or condition resulting in death)  Due to (or as a consequence of):   | Grandings from   | an- Krown  |
| Н              | Examiner  |                | Sequentially list conditions b. Corongry   | arken Disesse  | cu-known   |
|                | led<br>Insit  | niner          | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury                               |  |  |
| Ć.             | execut<br>in and<br>ial-trar  | Examine        | that initiated events c.  The sulting in death) Last Due to (or as a consequence of):  |  |  |
| 8760,          | icate be executed<br>physician and<br>s the burial-transit  | dical          | d  |  |  |
| 9              | eath certific<br>attending p  | /Mec           | IF FEMALE: 23c. If yes, outcome of pregnancy   |  | Ond Date of delication   |
| . Box          | The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as  | Physician/Me   | 1 ☐ Live birth 2 ☐ Fetal death 3 in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5                                       | □Ectopic pregnancy □ Other (specify)   | 23d. Date of delivery  Month Day Year                                      |
| P.O.           | that the de<br>ed by the<br>detached  | Phys           | 9 □ Unknown  |  |  |
|                | signed<br>d be def  | by             | Part II. Other significant conditions contributing to death but not resulting in the   | 11-1   | cco use contribute to the cause of death?  2 □ No 3 □ Probably 4 □₩fiknown |
| COL            | s been si   | olete          |  | 24a. Was an  | 24b. Were autopsy findings available                                       |
| Vital Records, | The law<br>cate has<br>page 2 (   | Completed      |  | autopsy<br>performe<br>1   | prior to completion of cause of death?                                     |
| Vita           | iician: Th<br>certificate<br>rector, pag  | Be             | 25. Was case referred to medical examiner?   | 26. Place of Death (Check only one)  |  |
|                | Phys  | ٦: T           | 27. Manner of Death 28a. Date of Injury 28b. Time (  |  |  |
| ion            | ttending I<br>death.<br>ctor: After<br>y the funer  | atlo           | 1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury<br>2 ☐ Accident investigation  | Work?<br>M 1 □ Yes 2 □ No  |  |
| Division of    | I or Attendater deatl   | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)                                    | treet, factory, office 28f. Location (Stre<br>City or Town,  | et and Number or Rural Route Number,<br>State)                             |
|                | spital  |                | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea  | ath occurred at the time, date and place, and due to the cau   | se(s) and manner as stated.  |
|                | To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.  | ledical        | (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.  | nvestigation, in my opinion, death occurred at the time, date  | e and place, and due to the cause(s)                                       |
| }              | on Con  | Σ              | 29b. Signature and title of certifier  |  | 1. Date signed (Month, Day, Year)  |
| n              | ~   |                | 30. Name and address of person who completed cause of death (Item 23a) (Type   | D-38754 C<br>Print) - RRN BLVD, M  | 21221  |
|                |   |                | MALIKA LASERM. 709. E  |  | 7-4144   |
| * £.           | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year)  JUL 2 1 2006  Starus II   | forther the same of the same o |  |

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ovest Haven
Social Security Number 6 atonsull Home Nursing Himore 8. Date of Birth (Month, Day, Year Sept. 16, Birthplace (State or Foreign Country) **Funeral** Days Year) 1 ☐ M 2 🕱 F Months Hours Min. 216-18-7429 82 1923 Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at Completed by Funeral Director MD 1 ☐ Yes 2 ☑ No Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or Items 23a 1034 Circle Drive 21227 U.S A.

14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 200 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 Machinist Koppers 17 Father's Name /First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental Himportent: If Itam 27 is marked of eny injury or other traumatic eve Pages 1 and 2 should be John Gatto Mary Alascio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Miller/Sister 345 Sullivan Drive Abingdon MD 21009 more, 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Denation 5 □ Other (Specify) 7-24-2006 Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility
Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd. Arbutus MD 21227 23a. Part. Enter the disease, or comblications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) TREBRO VASCILLAR ATH BLOSCLEROTIC **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of) the burial Box 68760, physician Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 □ Yes 2. □ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0 the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ Whknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 PNO 1 Yes 2 No 1 TYes 25. Was case referred to medical 26. Place of Death Check on one examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Other: Certification: To Nursing Home 5 Residence 6 Other (Specify) 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 TAccident investigation the 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 28555 eeu Name and address of person who completed cause of death (Item 23a) (Type, Print) 722 HSNEEM AKHANI 32 Registrar's Signature State Registrar

|                     |   | 1                 | For<br>State<br>Registrar  | State of M                                  | aryland                           |                           | rtmen<br>tificate                       |                         |                            | and Me                       |                                   | iene,                     | 006                             | 22879   |
|---------------------|---|-------------------|--|---|-----------------------------------|---------------------------|---|-------------------------|----------------------------|------------------------------|-----------------------------------|---------------------------|---------------------------------|---|
|                     |   |                   | 1. Decedent's Name (First, Middle, Las   | t)  |                                   |                           |   |                         |                            | 2                            | Date of Deat<br>Month             | h<br>Dav                  | Year                            | 3. Time of Death                              |
|                     | Physicia<br>/Medic  |                   | CATHERINE GRI  | FFIN  |                                   |                           |   |                         |                            |                              | 7                                 | 18                        | 2006                            | 3:00 PM                                       |
|                     | Examin  |                   | 4a. Facility Name (If not institution, give  | street and number)                          |                                   |                           | 4b. City,                               | Town, or                | Location o                 | of Death                     |                                   |                           | unty of Death                   | •   |
| п                   |   | ш                 | 1312 AGORA PLA   | Œ   |                                   |                           | BE                                      | LAI                     | R                          |                              |                                   | (4)                       | ARFUR                           |   |
|                     | Funeral   |                   | 5. Social Security Number 6. S   |   | je (In yrs. last                  |                           | If Under<br>Months                      | 1 Year<br>Days          | If Under 2                 | Min.                         | . Date of Birth<br>(Month, Day,   | Year)                     | 9. Birth                        | place (State or Foreign ntry)                 |
|                     | Director  |                   | 21, 30 23,3  | L M ZLXF                                    | 65<br>                            | Yrs.                      |   |                         |                            | Jı                           | ı1y 4,                            | 1941                      | Mary                            | land  |
|                     | pur *   | -                 | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, T                      | own or Lo                 | cation                                  |                         |                            |                              |                                   |                           |                                 | 10d. Inside City Limits                       |
|                     | sho   | ō.                |  | 1   |                                   |                           |   |                         |                            |                              |                                   |                           |                                 | 1 ☐ Yes 2 ☐ No                                |
|                     | Ne N<br>289-f   | ect               | Md. Harfor  10e. Street and Number   | d   |                                   |                           | Be1                                     |                         |                            |                              | 1                                 | On Citizer                | of What Cou                     | ntry?   |
|                     | with  | Funeral Director  |  |   |                                   |                           | 101. 2.0                                |                         | 1014                       |                              |                                   | U.S                       |                                 | ,   |
|                     | s 23  | erai              | 1312 Agora Place   | 12. Was Decedent                            | Ever in U.S.                      | 13 \                      | Nas Decer                               |                         |                            | gin? (Specif                 | v Yes or No-                      |                           | Race - Ameri                    | can Indian.                                   |
|                     | er de<br>Item   | nu.               | <ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>   | Armed Forces?                               | ?                                 | 10.1                      | f Yes, spec                             | ify Cuba                | n, Mexican                 | , Puerto Rio                 | ly Yes or No-<br>can, etc.)       |                           | Black, White,                   |   |
| 36                  | l', or  | by                | 3 ☐ Widowed 4 ☑ Divorced   | If Yes, Give<br>Year or Dates:              |                                   |                           | 1 🗆 Yes                                 | 2₩ No                   | Specify:                   |                              |                                   | Sp                        | ecify: V                        | hite  |
| ş                   | within 72 hours after death with the Maryland<br>ene.<br>then "naturel", or llems 23e or 28e-f show<br>La Modical Exercit et must te rodified at  | be                | 15. Decedent's Ed  | lucation                                    | 1                                 | 6a. Deced                 | dent's Usua                             | I Occupa                | ation                      |                              |                                   | 16b. Kind                 | of Business/In                  | dustry  |
| 12                  | n"n   | pie               | (Specify only highest gra  | de completed)  College (1-4or               | 5+)                               | life. l                   | DO NOT us                               | rk done d<br>se retired | iu <i>ring m</i> osi<br>)  | t of working                 |                                   | ,                         |                                 |   |
| 212                 | l with  | Completed         | Liementary/3000/dary (0°12)  | 5+  |                                   | teach                     | er                                      |                         |                            |                              |                                   | eau                       | cation                          |   |
| פַ                  | e filed very Hygie other t  | Be C              | 17. Father's Name (First, Middle, Last)  |   |                                   |                           |   |                         | 18. Mothe                  | er's Name (I                 | First, Middle, I                  | Maiden Su                 | mame)                           |   |
| ā                   | Ald be hental rked o  | ToE               | Andrew Zawacki   |   |                                   |                           |   |                         | Sopl                       | hia Wı                       | coblews                           | ki                        |                                 |   |
| Maryland 21215-0036 | shot<br>and N<br>s ma   |                   | 19a. Informant's Name/Relationship (   | Type, Print)                                |                                   | 19b. Mailir               | ng Address                              | (Street a               | and Numbe                  | er or Rural F                | Route Number                      | , City or To              | own, State, Zij                 | Code)   |
|                     | alth alth 27 i  |                   | Christopher A. Gr  | iffin/son                                   |                                   |                           |   |                         | l Road                     |                              | ltimore                           |                           |                                 |   |
| ore                 | of He<br>of He<br>item  |                   | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐  |   | cem                               | etery, crer.              | sition (Nar<br>natory or o              | ther plac               | e)                         | Dat                          |                                   |                           | ion - City or T                 |   |
| Ë                   | Page<br>nent on<br>int: If  |                   | * 4 ☐ Donation 5 ☐ Other (Specif   | (1)   | Holy                              | Rosa                      | ry Ce                                   | emete                   | ery                        | 7/22/0                       | 06                                | Balt:                     | imore,                          | Md.   |
| Baltimore,          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or Items 23e or 28e-1 show amy injury or other treumatic event, It a Modical Exercited must be rediffed at any injury or other treumatic event, It a Modical |                   | 21/S gnature of uneral Pervice Licer   | 1500  |                                   | S                         | chimu                                   | ınek                    |                            | ral Ho                       | ome of                            |                           |                                 |   |
|                     |   |                   | 23 Part. Enter the disease, or com   | blications that cause                       | d the death.                      | Do not ent                | er the mod                              | Mac<br>le of dyin       | Phai<br>g, such as         | L Road                       | Bel<br>espiratory arr             | Air,<br>est,              | Md. 21                          | Approximate                                   |
|                     |   | i i               | Shock, or heart failure. List only<br>Impediate Cause (Final   | one cause on each I                         | ine.                              |                           |   |                         |                            |                              |                                   |                           |                                 | Interval Between<br>Onset and Death           |
|                     | Fnysician<br>/Medical   |                   | disease or condition resulting in death)   | a   | CAROI<br>a consequer              | AL I                      | NFAF                                    | XCT13                   | N                          |                              |                                   |                           | -                               |   |
|                     | Examiner  |                   |  | Due to (or as                               | s a consequen                     | 100 01).                  |   |                         |                            |                              |                                   |                           |                                 |   |
|                     | - 3   | ē                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | b. Due to (or as                            | a consequer                       | nce of):                  |   |                         |                            |                              |                                   |                           |                                 |   |
|                     | uted<br>d<br>ansit  | ᇤ                 | Cause (Disease or injury that initiated events   | C   |                                   |                           |   |                         |                            |                              |                                   |                           |                                 |   |
| Ć.                  | execin an   | Examiner          | resulting in death) Last   |   | a consequer                       | nce of):                  |   |                         |                            |                              |                                   |                           | _                               |   |
| 8760,               | death certificate be executed e attending physician and of for use as the burial-transit  |                   |  | d   |                                   |                           |   |                         |                            |                              |                                   |                           |                                 |   |
| 9                   | tificat<br>ig phy<br>as th  | Physician/Medical |  |   |                                   |                           |   |                         |                            |                              |                                   |                           |                                 |   |
| Вох                 | that the death certifics<br>ed by the attending pt<br>detached for use as t   | N/u               | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome                        |                                   |                           | ]Ectopic pi                             | regnancy                |                            |                              |                                   | 230                       | . Date of deliv                 | *   |
|                     | death   | icla              | in the past 12 months? 1 Yes 2 No  | 4☐Pregnant a                                |                                   |                           | Other (sp                               |                         |                            | -                            |                                   |                           | Month                           | Day Year                                      |
| P.<br>0             | law requires that the<br>as been signed by th<br>2 should be detache  | hys               | 9 🗆 Unknown  |   |                                   |                           |   |                         |                            |                              | T                                 |                           |                                 |   |
|                     | w requires that<br>been signed b<br>should be deta  | by F              | Part II. Other significant conditions of   | contributing to death                       | but not resulti                   | ng in the u               | nderlying o                             | ause give               | en in Part I.              |                              |                                   |                           |                                 | he cause of death?                            |
| ord                 | aquire<br>en si<br>ould l   |                   | STROKE   |   |                                   |                           |   |                         | _                          |                              | 1 🗆 Y                             | es 2 <del>1</del>         | 10 3 Pro                        | bably 4 Unknown                               |
| SC                  | has be  | pie               |  |   |                                   |                           |   |                         |                            |                              | 24a. Was a autops                 | SV                        | 4b. Were auto                   | opsy findings available ompletion of cause of |
| Vital Records,      | The ate had bage  | Completed         |  |   |                                   |                           |   |                         |                            |                              | perfor                            |                           | death?                          | 2□ No   |
| ital                | ysicien: The is certificate his director, page  | Bec               | 25. Was case referred to medical examiner?   |   |                                   |                           |   |                         | 26. Place                  | of Death (                   | Check only or                     | 16)                       |                                 |   |
|                     | Physicien:<br>this certific<br>ral director,  | To                | 1 Yes 2 No   | Hospital: 1   Inpat                         | ient 2 EF                         | VOutpatier                | nt 3 DC                                 | Oth Oth                 | er: 4□ Nu                  | ırsing Home                  | 5 <b>A</b> Reside                 | ence 6 [                  | Other (Speci                    | fy)   |
| n of                | Jing Pt.<br>After th  |                   | 27. Manner of Death  1. Natural 5 Pending  | 28a. Date of Inj<br>(Month, D.              | ury<br>ay Year) 28                | Bb. Time o<br>Injury      | f 2                                     | 28c. Injun<br>Worl      | y at<br>k?                 | 28                           | d. Describe h                     | ow injury o               | ccurred                         |   |
| <u>Ö</u>            | Attsnding r death. Bctor: After by the fune   | atic              | 2 ☐ Accident investigatio  | 1   |                                   |                           | М                                       | 1 🗆                     | Yes 2 🗆                    |                              |                                   |                           |                                 |   |
| Division            | or Attsnuafter death  | Certification:    | 3 Suicide 6 Could not be determined  | 288. Flace of II                            | njury - At home<br>etc. (Specify) | e, farm, sti              | reet, factor                            | y, office               |                            | 28                           | f. Location (S<br>City or Tow     | treet and N<br>n, State)  | lumber or Rur                   | al Route Number,                              |
|                     | itel or<br>irs afte<br>rei Dir<br>led in  | Cer               |  |   |                                   |                           |   |                         |                            |                              |                                   |                           |                                 |   |
|                     | e Hospitel<br>24 hours a<br>e Funerei E<br>etely filled   | dical             | (Check only 2 Medical Example 12 Medical Example | nysician: To the bes<br>miner: On the basis | of examination                    | edge, deat<br>n and/or in | h occurred<br>vestigation               | at the tin              | ne, date an<br>pinion, dea | nd place, an<br>oth occurred | d due to the c<br>Lat the time, d | ause(s) an<br>late and pl | d manner as s<br>ace, and due t | stated.<br>to the cause(s)                    |
|                     | To the Hospitel or Attanding Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral   | Medi              | one)   | and manner s                                |                                   |                           |   |                         | e number                   |                              |                                   |                           | igned (Month,                   |   |
|                     | To To Con   | ~                 | 29b. Signature and title of certifier  | 0.5   |                                   |                           |   |                         |                            |                              |                                   |                           |                                 |   |
| 7                   | 4   |                   | Philip W. Ha   | lotead no                                   |                                   |                           |   | 0005                    | 0803                       |                              |                                   | 711                       | 9/06                            |   |
| //                  | 2   |                   | 30. Name and address of person who   |   |                                   |                           |   |                         |                            |                              |                                   |                           |                                 |   |
| 10                  | /   |                   | PHILIPW. HALSTE  | 00 m 0 60                                   | TUVE Signatur                     | N AT                      | 0000                                    | F-D                     | BEL.                       | AIR, N                       | ~0 401                            | 4                         |                                 |   |
|                     |   | ate               | 31. Date filed (Month, Day, Year)  | 106 32 legis                                | trar's Signatur                   | ST.                       | will                                    |                         |                            |                              |                                   |                           |                                 |   |
|                     | Regist  | Tal               | JUL 2 1 20   | 100   | ~ N                               | 14                        | - P - P - P - P - P - P - P - P - P - P |                         |                            |                              |                                   |                           |                                 |   |

DHMH 17 Rev 1/2001

|  |               | 1 - For<br>State<br>Registrar  | State of Man                                   |                      | partment of Herrificate of L  |  |                                    | iene<br>9. No 2006                     | 22880  |
|--|---------------|--|--|----------------------|---|--|------------------------------------|--|--|
| 4.5  | 1. 6          | Registrar     Decedent's Name (First, Middle, Last                         | st)  |                      |   |  | 2. Date of Deat                    | h                                      | 3. Time of Death                                 |
| Physici  | - 0           |  |  |                      | Getty   |  | Month<br>July                      | 17. 2006                               | 9:15P M  |
| /Medic<br>Examin   |               | Florence 4a. Facility Name (If not institution, give                       |  |                      |   | Location of Death                          | JULY                               | 4c. County of Deal                     |  |
| LAGITIII   | ÇI<br>A       | 7026 Eldanbak  | Dand   |                      | D   | d  |                                    | A                                      |  |
| Funeral  |               | 7936 Elizabeth 5. Social Security Number 6. S                              | ex 7. Age (//                                  | n yrs. last birthda  | y) If Under 1 Year  | dena<br>If Under 24 Hrs.                   | 8. Date of Birth                   | Anne A                                 | Arundel hptace (State or Foreign buntry)         |
| Director   |               | 217-24-7315  | □M 202/F                                       | Yrs.                 | Months Days   | Hours Min.                                 | June 19                            |  | aryland  |
| D .  |               | Usual Residence of Decedent  |  |                      |   |  |                                    | 2,1,720 IN                             |  |
| rylan  |               | 10a. State 10b. County   | 10   | Oc. City, Town or    | Location  |  |                                    |  | 10d. Inside City Limits                          |
| e Ma   | Director      | Maryland Anne  | Arundel  | Pasadena             | a   |  |                                    |  | 1 Yes 2 NAO                                      |
| ih th  | Oire          | 10e. Street and Number   |  |                      | 10f. Zip Code   |  | 11                                 | 0g. Citizen of What Co                 | ountry?  |
| 23a  | a             | 7936 Elizabeth Ro  | ad   |                      | 211   | 22   |                                    | U.S.                                   |  |
| r dea  | Funeral       | 11. Marital Status   | 12. Was Decedent Eve<br>Armed Forces?          | er in U.S. 13        | <ol> <li>Was Decedent of His<br/>If Yes, specify Cuba</li> </ol>        | ispanic Origin? (Sp<br>in, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)   | 14. Race - Ame<br>Black, Whit          |  |
| or th  |               | 1 Never Married 2 Married  | 1 ☐ Yes 2 ☑ No<br>If Yes, Give                 |                      | 1 ☐ Yes 2 ☐ No  | Specify:                                   |                                    | Specify:                               |  |
| itied within 72 hours after death with the Maryland Hygiene. Hygiene. Ither than "netural; or Items 23s or 28e-f show on, the Madical Examiner must be ricillised at   | d by          | 3 ☑ Widowed 4 □ Divorced   | Year or Dates:                                 |                      |   |  |                                    |  | √hite  |
| net<br>rife  | Completed     | 15. Decedent's Ed<br>(Specify only highest gra                             | lucation<br>de completed)                      | 16a. Dec             | cedent's Usual Occupa<br>ve kind of work done o<br>. DO NOT use retired | ation<br>during most of work               | ing                                | 16b. Kind of Business                  | Industry   |
| Marking Market   | mp            | Elementary/Secondary (0-12)  | Cotlege (1-4or 5+)<br>N/A                      | ille                 |   |  |                                    | O II                                   |  |
| dygie dy nt.   |               | 17. Father's Name (First, Middle, Last,                                    |  |                      | Housewif  | 18. Mother's Nam                           | a (First Middle A                  | Own Home                               | 2  |
| be f<br>d of   | Be            |  |  |                      |   |  |                                    |  | _ <b>L</b>                                       |
| I all y latter & 12.  2 should be filed within and Mental Hygiene.  Is marked other than reumatic event, the Market was the Ma | 2             | Walter   | C.   | Moody,               |   | Minnie                                     |                                    | Undut                                  |  |
| ie, well yielled within 22 to 2000. If and 2 should be filed within 72 hours after death with the Maryla freath and Mental hygiene it freath and Mental hygiene. It was 23s or 28e-f show then treumatic event, the Medical Examiner must be notified at   |               | 19a. Informant's Name/Relationship (                                       |  |                      |   |  |                                    | City or Town, State, 2                 |  |
| and 27   |               | Joyce E. Klebe ()  |  | 20h Place of Dis     | 3 220th S   | treet Pas                                  | sadena, M                          | laryland 21<br>20c. Location - City or | Town State                                       |
| permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other ance.   |               | 1 Purial 2 Cremation 3   |  | cemetery, c          | rematory or other place   | (e)  |                                    | 20c. Cocation - City of                | TOWII, State                                     |
| Pa<br>tmen<br>tant:  |               | 4 Donation 5 Other (Specif   |  |                      | ven Mem. P  |  | /06                                | Glen Burni                             | e, Maryland                                      |
| Dermit<br>Depart<br>Import<br>any in   |               | 21. Signature of Funeral Service Licer                                     | ISOO   |                      | 22. Name and Addres   |  | unoral E                           | Iomo D A                               |  |
| 4 40 E E G   |               | 11/1   | Ellins   |                      | 3204 Moun   | tain Road                                  | Pasader                            | Home, P.A.<br>na, Marylan              |  |
|  |               | 23a. Papt. Enter the disease, or com<br>shock, or heart failure. List only | one cause on each line.                        |                      |   |  |                                    | ,                                      | Approximate<br>Interval Between                  |
| Physician  |               | Immediate Cause (Final disease or condition                                | Arte   | riosc                | lerotic   | - He                                       | Art 1                              | DISCHED                                | Onset and Death                                  |
| /Medical   |               | resulting in death)  | Due to (or as a c                              |                      |   |  |                                    |  |  |
| Examiner   |               | Sequentially list conditions,  | b  |                      |   |  |                                    |  |  |
| D =  | ner           | if any, leading to immediate cause. Enter Underlying                       | Due to (or as a c                              | onsequence of):      |   |  |                                    |  |  |
| be executed iclen and burial-transit   | Examiner      | Cause (Disease or injury that initiated events                             | c  |                      |   |  |                                    |  |  |
| e exe  | Ä             | resulting in death) Last   | Due to (or as a c                              | onsequence of):      |   |  |                                    |  |  |
| cate be executed only sicien and the burial-transit  | dical         |  | d  |                      |   |  |                                    |  |  |
| The law requires that the death certificate the has been signed by the ettending physpage 2 should be detached for use as the  | Ved           | IF FEMALE:   |  |                      |   |  |                                    |  |  |
| th ce  | an/l          | 23b. Was decedent pregnant   | 23c. If yes, outcome of p<br>1 Live birth 2 [  |                      | 3 □Ectopic pregnancy  | ,  |                                    | 23d. Date of del<br>Month              | ivery<br>Day Year                                |
| he el  | sici          | in the past 12 months?   | 4☐Pregnant at tim<br>9☐Unknown                 | ne of death          | Other (specify)   |  |                                    | World                                  | Cay Toal   |
| w requires that the death certific wequires that the death certific been signed by the ettending p should be detached for use as:  | Physician/Me  | 9 Unknown  |  |                      |   |  | an Dide                            |  | 1 - 1 - 1 - 1 - 1 - 1                            |
| es the   | ğ             | Part II. Other significant conditions of                                   | ontributing to death but r                     | not resulting in the | underlying cause give   | en in Part I.                              |                                    | pacco use contribute to                |  |
| requir<br>sen si   | ted           |  |  |                      |   | -  | 1 Lyre                             | s 2 No 3 Pr                            | obably 4 Unknown                                 |
| as be  | ple           |  |  |                      |   |  | 24a. Was ar                        | n 24b. Were au                         | atopsy findings available completion of cause of |
| The<br>The   | Completed     |  |  |                      |   |  | perform                            | ned? death?                            | 31   |
| DIVISION VICE INC.  To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.  | Bec           | 25. Was case referred to medical   |  |                      |   | 26. Place of Deat                          | h (Check only on                   | _                                      |  |
| To the Hospital or Attanding Physician: within 24 hours after death. To the Funarel Director: After this certifical completely filled in by the funeral director.  | To            | examiner?<br>1 X Yes 2 No  | Hospital: 1 ☐ Inpatient                        | 2 ER/Outpat          | ient 3 DOA Oth  | er: 4 Nursing Ho                           | me 5 Reside                        | nce 6 Other (Spe                       | cify)  |
| terth<br>Derai   |               | 27. Manner of Death  | 28a. Date of Injury<br>(Month, Day Y           | (ear) 28b. Time      |   | y at                                       | 28d. Describe ho                   | w injury occurred                      |  |
| nding<br>ath.<br>r: Afte   | atic          | 1 ANatural 5 Pending 2 Accident investigatio                               |  | ,                    |   | Yes 2 □No                                  |                                    |  |  |
| Afte octo  | ertification: | 3 Suicide 6 Could not be determined  |  |                      | street, factory, office   |  | 28f. Location (Sti<br>City or Town | reet and Number or Ru<br>State)        | ural Route Number,                               |
| S S S S S S S S S S S S S S S S S S S  | Cert          |  | Sanding, old. (                                | оросну)              |   |  |                                    | , 5.0.0)                               |  |
| psplt<br>hour<br>mere<br>y fille   |               |  | ysician: To the best of r                      |                      |   |  |                                    |  |  |
| ne Ho  | edical        | (Check only 2 Medical Examone)   | ninar: On the basis of ex<br>and manner stated |                      | investigation, in my o  | pinion, death occur                        | red at the time, da                | ate and ptace, and due                 | to the cause(s)                                  |
| To the To the COM  | Σ             | 29b. Signature and title of certifier                                      | m.   | Depu                 | 1 29c. License  | e number                                   | ch 25                              | 9d. Date signed (Mont                  | h, Qay, Year)                                    |
|  |               | 1/ telle   | -Makes   | mo                   | D   | 61600                                      | 7                                  | 7/19                                   | 16   |
| 16   |               | 30. Name and address of person who   | completed cause of deat                        | th (Item 23a) (Typ   | e, Print)   | 0605<br>Amer                               | _                                  |  |  |
| ()   |               | Milliam P  | Joves  | 3,mD                 | 695   | Amer                                       | ien                                | 2103                                   | 5  |
| Sta Sta  | ate           | 31. Date filed (Month, Day, Year)  | 32. Registrar's                                | Signature            | ,   |  |                                    |  |  |
| Regist   | rar           | JUL 2 1 200  | 6 Feet   | H. do                | reles   |  |                                    |  |  |
| DHMH 17 Rev 1/2  | 001           |  | Judion   | 7                    |   |  |                                    |  |  |
|  |               |  |  | ORIG                 | SINAL   |  |                                    |  |  |

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

|   |                  | 1- For State Control of Treatment of Treatme | ai i iygi                 | Reg.                                | No. 20                      | 06 2288  |
|---|------------------|--|---------------------------|-------------------------------------|-----------------------------|--|
| Physicia<br>edical Exami  |                  | 1. Decedent's Name (First, Middle, Last) Christian Gil-Nunez   | I N                       | Date of Death<br>Month Duly 18, 200 | Day Year                    | 3. Time of Death<br>0340 hrs                           |
|   |                  | 4a Facility Name (if not institution, give street and number)  4b. City, Town, or Location of E  |                           | Jily 10, 200                        | 4c. County of De            |  |
|   |                  | 4800 Franklintown Road Baltimore  5. Social Security Number  | 0.411 To                  | Data of Birth                       |                             | /JA  |
| Funeral<br>Director   | 9                | 219-71-5532 1 XM 2 F 38 Yrs. Months Days Hours   | Min.                      | Jov. 9, 1                           | FO.                         | Pirthplace (State or reign Dominican Country) Republic |
| any   |                  | Usual Residence of Decedent  10a. State  |                           |                                     |                             | 10d. Inside City Limits                                |
| and<br>F show<br>once.  | ō                | Maryland N/A Baltimore   |                           |                                     |                             | 1 Yes 2 No   |
| imore, MD 21215-0036  Pages I and 2 should be filed withn 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Tant: If them 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once. | Funeral Director | 10. Street and Number 101. Zip Code 1413 CaCavendish Way 21224   | í                         | 10g.                                | Citizen of What C           | ountry?  |
| death with  | -unera           | 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. / 13. Was Decedent of Hispanic Origin;   1 Never Married 2 Married   1 Yes 2 No   | ? ( Specify<br>uerto Rica | Yes or No-<br>in, etc.)             | 14. Race - Ar<br>White, etc | nerican Indian, Black,<br>:                            |
| rs after<br>ural",<br>miner   |                  | 3 Widowed 4 Divorced If Yes, Give Year 1 No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind)   |                           | ni Can                              | Specify: V                  | Inite  |
| 72 hou<br>m "nat  | leted            | Elementary/Secondary (0-12) College (1-4 or 5+)  |                           |                                     |                             | Soft Tadoxy  |
| within giene.   | Completed by     | 17. Father's Name (First, Middle, Last)  Nanager 17. Father's Name (First, Middle, Last)   | Nome /Fire                | st, Middle, Mai                     | Bas                         |  |
| D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica  | Be C             | Viterbo Gil Ana  |                           | elia                                | Nune                        | 22   |
| D 21<br>should<br>and Me<br>7 is man  | ပ                | 19a. Informant's Name/Relationship (Type, Print) (1), e 19b. Mailing Address (Street and Numbe   | 1 . /                     | Route Numbe                         | er, City or Town, St        | ate, Zip Code)   |
| re, MD 1 and 2 sho Health and fitem 27 is   |                  | NIS Wanda Cepeda 143 (aCavend<br>20a. Method of Disposition (Name of cemetery,   | , Da                      |                                     | Oc. Location - City         | or Town, State   |
| Baltimore,<br>permit. Pages I a<br>Department of He<br>Important: If ite  |                  | 1 Name of the place of the specify:  1 Name of the place  | 7/25/                     | 2006                                | Santing                     | Dominican  |
| Baltimo<br>permit. Page<br>Department o<br>Important:<br>injury or otd  |                  | Signature of Funeral Service Liceasee  | CF                        | 1 5000                              | 11 Home                     | P.A.   |
| Physician   | S (1)            | 2222 W. North<br>23a Part I. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as card   | Ave                       | piratory arrest                     | shock, or heart             | 21216<br>Approximate Interval                          |
| /Medical<br>Examiner  |                  | Ufailure. Listonly one cause on each line.<br>  Immediate Cause (Final disease a. Gunshot wounds (2) of the head   |                           |                                     |                             | Between Onset and<br>Death                             |
| -xammer   |                  | or condition resulting in death)  Due to (or as a consequence of):   |                           |                                     |                             |  |
|   | iner             | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause  |                           |                                     |                             |  |
| 1 = =   | Examiner         | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):   |                           |                                     |                             |  |
| xecuted<br>n and<br>l - trans   |                  | dunpended Amended  |                           |                                     |                             |  |
| 760, ficate be executed g physician and the burial - transit  | Medical          | IF FEMALE: 23c. If yes, outcome of pregnancy   |                           |                                     | 23d. Date of deliv          | rery   |
| 68760,<br>certificate be<br>nding physic<br>se as the bur   |                  | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pr   | regnancy                  |                                     | Month                       | Day Year   |
| , P.O. Box 68 ires that the death certification is signed by the attending be detached for use as   | Physician        | 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown   |                           |                                     |                             |  |
| P.O. ss that the gned by a detache  | by PI            | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I  | l.                        |                                     |                             | to the cause of death?                                 |
| ords, F<br>w requires<br>is been sig  |                  | ··   | - 1                       | 24a. Was an                         |                             | autopsy findings available                             |
| 10 E E C  | Completed        |  | -                         | autopsy<br>performe                 | ed? death                   |  |
| al Rec<br>an: The strifficate stor, page  | a)               | 25. Was case referred to medical 26. Place of Death (Ch  | heck only o               | 1 Yes 2 one)                        | No 1 🗸                      | Yes 2 No   |
| F Vital Physician: r this certif  | To B             | 160 2 110  |                           |                                     | sidence 6 🗸 Ot              | her Scene  |
| _ <b>=</b> □ ^ ∉ I  | Certification:   | 27. Manner of Death  1 Natural 5 Pending Prounds Investigation 19 11 18, 2006  28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  FOUND: 1 Yes 2 No. 0323 hrs   | Sub                       | pject shot                          | v injury occurred           |  |
| Division pital or Attendi ours after death teral Director: /  | tifica           | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.  |                           | or Town State                       | 9)                          | Rural Route Number, City                               |
| file of pi  |                  | 4 Homicide determined (Specify) Local Street   | 480                       | 0 N. Frank                          | lintown Road,               | Baltimore, MD  |
| To the Hos<br>within 24 h<br>To the Fur<br>completely   | Medical          | (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one)  2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occur and manner stated   |                           |                                     |                             |  |
| To with   | Me               | 29b. Signature and title of certifier 29c. License number  |                           | - 1                                 | 9d. Date signed (i          | Month, Day, Year)                                      |
|   |                  | Paniek Southay, ND O.C.M.E.  |                           | J                                   | July 18, 2006               |  |
| 3   |                  | Name and address of person who completed cause of death (Item 23a)     Pamela Southall, MD   | MD 212                    | 201                                 |                             |  |
| S<br>Regis  | tate<br>trar     |  |                           |                                     |                             |  |
| - 10913   |                  | The state of the s |                           |                                     |                             |  |

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

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LINDA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:05 PM Lucie Hodges Geckler July 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days | Hours | Min. | July 15, 1 9. Birthplace (State or Foreign Country) 1917 South Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 212-18-7551 88 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. tnside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Itema 23a or 28a-1 ehow empt injury or other traumatic event, the Medical Examinar must be notified at once. 1 ☐ Yes 2 💢 No Maryland Baltimore Ruxton Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7001 N. Charles St. 21204 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XX No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: Specify: white ģ 3 ☐ Widowed 4 XXDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) teacher education 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (unknown) Hodges unknown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2930 E. Baltimore St. Charles Wargo/personal represen. Baltimore, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Greenmount crematory July 21,2006 Raltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerat Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 a fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Complications Dementing **Physician** scars /Medical Due to (or as a consequence of): Examiner Sequentially tist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ending physician and ouse as the burial-transit or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Cther (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence & Other (Specify) NOSPLY 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 [T] Homicide the Hospital ⁄ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 15 2006 3 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) CHARVES, NO 660 [NOSTH CHARVES ST BALTUNE UN ZIZO4 AMIN

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 1 2006

ORIGINAL

Bleen & Grand

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 20:374 200h OHN (011350V /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6. Sex 7. Age (In vrs. last birt Baltimoli Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) (In yrs. last birthday) 37 Yrs. 6. Sex 1 □ AM 2 □ F Birthplace (State or Foreign Country) **Funèral** 28. Director 345-72-8882 1968 Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "netural", or Itama 23a or 28a-f ahow the Medical Exeminar must be notified at 1 ☐ Yes 2 No Director MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 Gardier Drive 21001 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours effer nent of Heelth and Mental Hygiene. nt: if Item 27 is marked other then "netural", or Ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White white Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Wave Corp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John N. Gibson Joanne Shallers ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33415 19a. Informant's Name/Relationship (Type, Print) Department of Heelth a Important: If Itam 27 is any injury or other traconce. John N. Gibson - Father 1270 Parkside Green Drive West Palm Beach, FL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory July 14, 06 Baltimore, MD 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Road Baltimore, MD 21228 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part./ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Complications of SELE INKLICTED STABLOOMS Immediate Cause (Final disease or condition resulting in death) 7 mouth Physician /Medical CERTIFICATION APPROVED BY MEDICAL DYMMINER IVER FAIWRE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No 9 Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 9:15 m 1 Natural 5 Pending 1 TYes 2-08-2006 2 Accident investigation SUBJET STAR 281. Location (Street and Number City or Town, State) 2 15 6 Could not be determined Suicide

Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) er or Rural Route Number

Examiner been signed by the attending physicien and should be detached for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. certificete has birector, page 2 si After this c within 24 hours enter ....
To the Funeral Director: Aft

deeth with the Maryland

Baltimore, Maryland 21215-0036

ABERDEEN MA 21001 HOWE 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number anciona m 00063970 pleted cause of death (Item 23a) (Type, Print) ue los BOUTIMORE MD 5 GRETILE ST. MUSINA FATHERIN MOTERL

State Registrar

8

Medical

31. Date filed (Month, Day, Year) 21

egistrar's Signature 32. 2006

06-05201 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Malcolm Garrison 1- For State Certificate of Death Reg No Registra Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 19, 2006 0218 hrs **Medical Examiner** Malcolm J. Garrison Jr 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 3509 E. Lombard Street Baltimore Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign CoWintginia Hours Months Davs Director 1949 Jan. 1, 1 X M 2 57 215-52-3891 Usual Residence of Decedent 10b County 10c. City. Town or Location 10d Inside City Limits any 1 X Yes 2 No 23a or 28a-f show notified at once, n/a Baltimore MD hours after death with the Maryland Director 10f. Zip Code 10g Citizen of What Country? 1Ce. Street and Number 21224 USA 3509 East Lombard Street Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-11. Marital Status 14. Race - American Indian, Black White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married No. 1968 1971 1 Yes 2 X No specify Widowed 4 X Divorced If Yes. Give Year Specify: white white à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed ages 1 and 2 should be filed within 72 ho. nt of Health and Mental Hygiene during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) njury or other traumatic event, the Medical MD 21215-0036 Disabled Disabled 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Via Malcolm J. Garrison Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 South Ellwood Ave. Baltimore, MD 21224 Patricia Graber - Daughter 20c. Location - City or Town, State 20a. Method of Disposition Itimore, crematory or other place) Burial 2 X Cremation 3 Removal from State mportant: Donation 5 Other Specify Metro Crematory July 24. 06 Baltimore, MD <sup>22</sup>Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 Signature of Funeral Service aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician /Medical ert I. Enter the disease, or complications that Between Onset and Death allure. List only one cause on each line. a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical UNPENDED **AMENDED** Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Dav Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Emphysema Completed Records, 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other Nursing Home 5 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other: Scene 1 🗸 Yes 2 No 28a, Date of Injury (Month, Day,Year 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 V Natural 1 Yes 2 No 5 Pending Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year)

3

State

Registra

Name and address of person who completed cause of death (Item 23a)

2006

Day, Year)

Laron Locke MD.

31. Date filed (Month, Day

Assistant Medical Examiner

istrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 19, 2006

|            |  |                | For<br>State<br>Registrar  | State of  | Marylan                           |                       | artment of F                                     |                               | nd Menta                     | l Hygien                               | ZIIIIb                      | 22885   |
|------------|--|----------------|--|---|-----------------------------------|-----------------------|--|-------------------------------|------------------------------|--|-----------------------------|---|
|            | Physici  | an             | Decedent's Name (First, Middle, La   |   |                                   |                       |  |                               | 2. Date<br>Mor<br>07         | of Death                               | 2006 Year                   | 3. Time of Death  11:35a M                    |
|            | /Medic   | al             | Marta Elena Gano  4a. Facility Name (If not institution, giv                           |   | her)                              |                       | 4b. City, Town, o                                | r I ocation of                |                              |  | c. County of Dea            |   |
| No.        | Examir   | ier            | 9039 Sligo Creek   |   |                                   |                       | Silver   |                               |                              |  | Montgo                      |   |
|            | Funeral<br>Director  |                | 031-42-3779  | ex 7.<br>I□M 2⊠F                                | Age (In yrs. I                    | ast birthday)<br>Yrs. | If Under 1 Year<br>Months Days                   | If Under 2<br>Hours           | 8. Date (Moi<br>Min. 04      | of Birth<br>orth, Day, Year<br>-08-194 | 9. Bii                      | thplace (State or Foreign<br>ountry)<br>Chile |
|            | and  |                | Usuat Residence of Decedent  10a. State 10b. County                                    |   | 10c. City                         | , Town or Lo          | ocation  |                               |                              |  |                             | 10d. Inside City Limits                       |
|            | Maryi<br>-f ehc  | ţō             | MD Montg   | omery   | S                                 | ilver                 | Spring   |                               |                              |  |                             | 1 ☐ Yes 2 No                                  |
|            | with the<br>a or 28a   | Director       | 10e. Street and Number<br>9039 Sligo Creek   | Parkway   | #1404                             |                       | 10f. Zip Code                                    | 20901                         |                              | 10g. C                                 | itizen of What C            | ountry?                                       |
| 9          | 72 hours after death with the Maryland<br>natural', or Items 23s or 28s-f ehow<br>iteal Examiner must be notified at | / Funeral      | 11. Marital Status 1 Never Married 2 Married   | 12. Was Deced Armed Force 1  Yes 2 If Yes, Give | ent Ever in U.<br>es?             |                       | Was Decedent of Hilf Yes, specify Cuba           | lispanic Orig<br>an, Mexican, |                              | s or No-<br>etc.)                      | 14. Race - Am<br>Black, Whi |   |
| 003        | 72 hours<br>natural',<br>orcal Ext   | q p            | 3 Widowed 4 □ Divorced   | Year or Dat                                     | es:                               | 162 Dage              | dent's Usual Occup                               |                               |                              | 165                                    |                             | /Industry                                     |
| 21215-0036 | within ne.   | Completed by   | 15. Decedent's E<br>(Specify only highest gra<br>Elementary/Secondary (0-12)           | College (1-4                                    | for 5+)                           | (Give<br>life.        | kind of work done DO NOT use retired Stered No   | during most<br>d)             | of working                   | 160.1                                  | Kind of Business  Medica    |   |
| and 2      | be filed<br>ital Hygi<br>d other<br>event, I   | To Be Co       | 17. Father's Name (First, Middle, Last, Jose Augustin Gu                               |   |                                   |                       |  | 18. Mother                    | r's Name (First,             |  |                             |   |
| Maryland   | s 1 and 2 should be f<br>Health and Mental is<br>tem 27 is marked of<br>other traumatic eve                          | ř              | 19a. Informant's Name/Relationship (Claudia Tassara/                                   |   |                                   | 19b. Mailii<br>6239   | ng Address (Street<br>33rd St                    | and Numbe<br>NW W             | r or Rural Route<br>lashingt | Number, City                           | or Town, State,             | Zip Code)                                     |
| Baltimore, | Pages 1 and<br>nent of Health<br>int: If Item 27<br>iry or other ti  |                | 20a. Method of Disposition  1  Burial 22 Cremation 3  4  Donation 5  Other (Specia     |   | a                                 | emetery, crei         | osition (Name of matory or other place ake Crema | atory                         | Date 07-19-2                 |  | ocation - City o            | Town, State                                   |
| Baltii     | permit, Pages<br>Department of<br>Important: If I<br>any injury or<br>once.  |                | 21. Signature of Funeral Service Lice  | nsee  | 01358                             | 22                    | Name and Addre<br>Rapp Fur<br>933 Gist           | eral i                        | & Crema                      | tion Se                                | rvice<br>MD 2091            | 0   |
| 1.4        |  |                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only            | plications that car                             | used the death                    | n. Do not en          |  |                               |                              |  |                             | Approximate<br>Interval Between               |
| á          | Physician  |                | Immediate Cause (Final disease or condition  | 2   | 1                                 | )an o                 | reers  | Can                           | cel                          |  |                             | Onset and Death                               |
|            | /Medical<br>Examiner   |                | resulting in death)  | Due to (o                                       | r as a consequ                    | uence of):            |  |                               |                              |  |                             | 7 montles                                     |
|            |  | <u>-</u>       | Sequentially list conditions, it any, loading to immediate                             | b. Due to (o                                    | ras a consequ                     | uence of              |  |                               |                              |  |                             | 1 money                                       |
|            | uted<br>d<br>ansit   | Examiner       | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events           | С.  |                                   |                       |  |                               |                              |  |                             |   |
| 50,        | be executed<br>sician and<br>burial-transit  | I Exa          | resulting in death) Last   |   | r as a consequ                    | uence of):            |  |                               |                              |  |                             |   |
| 68760,     | physic<br>physic<br>s the b  | dlcal          |  | _ d   |                                   |                       |  |                               |                              |  |                             |   |
| .O. Box (  | at the death certificate be executed<br>by the attending physician and<br>tached for use as the burial-transit       | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22□No 9 □ Unknown |   | th 2∐Fetal<br>ntattime of di      | death 3               | Ectopic pregnancy Other (specify)                | /                             |                              |  | 23d. Date of de<br>Month    | olivery<br>Day Year                           |
| Ω_         | ires tha<br>signed<br>d be de  | þ              | Part II. Other significant conditions  | contributing to dea                             | ath but not resi                  | ulting in the u       | nderlying cause giv                              | en in Part I.                 | 230                          |  |                             | o the cause of death?                         |
| Records,   | The law requate has been page 2 should   | Completed      |  |   |                                   |                       |  |                               |                              | a. Was an autopsy performed?           | prior to death?             |   |
| Vital      |  | BeC            | 25. Was case referred to medical   |   |                                   |                       |  | 26. Place                     | of Death (Check              |  | 0 1010                      | 2 110   |
| of V       | d is   | 70             | examiner?<br>1 ☐ Yes XXXNo   |   | patient 2                         |                       |  |                               | rsing Home 5                 |  |                             | ecify)  |
|            | ding Ph<br>h.<br>After th<br>funeral   | lon:           | 27. Manner of Death  XXNatural 5 ☐ Pending   | 28a. Date of<br>(Month                          | Injury<br>, Day Year)             | 28b. Time o<br>Injury | Wor  | yat<br>k?<br>Yes 2 □1         |                              | scribe how inti                        | ury occurred                |   |
| Division   | or Attendition (free death )   | Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined.                          | 28e. Place o                                    | of Injury · At hog, etc. (Specify | ome, larm, st         | reet, factory, office                            | 163 2                         | 28f. Loc                     | ation (Street a                        |                             | lurai Route Number,                           |
| _          | To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the           | Medical Ce     |  |   | sis of examina                    |                       | h occurred at the til<br>vestigation, in my c    |                               |                              |  |                             |   |
|            | To the<br>within<br>To the   | Me             | 29b. Signature and title of certifier  | /   |                                   |                       | 29c. Licens                                      | e number                      |                              | 29d. D                                 | ate signed (Mon             | th, Day, Year)                                |
|            |  |                | M  | 12  |                                   |                       | 0  | 350                           | 046                          |  | 7/                          | 812006  |
|            | 8  |                | 30. Name and address of person who Ruth He MD  |   |                                   |                       | Print)<br>NW Washir                              | ngton                         | DC 2000                      | 7                                      |                             |   |
|            |  | ate            | 31. Date filed (Month, Day, Year)  | 32 <b>/1</b> Re                                 | gistrar's Signa                   | ture                  |  |                               |                              |  |                             |   |
|            | Regist   | rar            | JUL 2 1 20   | Ub July   | lifted L                          | 1. 6                  | ents)  |                               |                              |  |                             |   |

DHMH 17 Rev 1/2001

|                            |  | ľ              | 1- State of Maryland / Department of Health and I Certificate of Death   |  | giene 200 (                                    | 5 22887  |  |  |  |  |
|----------------------------|--|----------------|--|--|--|--|--|--|--|--|
|                            | Dhysiai  | 2.00           | Decedent's Name (First, Middle, Last)  | 2. Date of Dea<br>Month                    |  | 3. Time of Death                                   |  |  |  |  |
|                            | Physici<br>/Medic  |                | Carolyn E. Giammona  | July 1                                     | 8 2006   |  |  |  |  |  |
| Ž.                         | Examin   | er             | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death   | 1  | 4c. County of Dea                              | in   |  |  |  |  |
|                            | Funeral  |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day            | 9. Bir   | thplace (State or Foreign                          |  |  |  |  |
|                            | Director   |                | 219-32-9597 68 Yrs. 68   | 12-21-                                     |  | yland  |  |  |  |  |
|                            | land   |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |  |  | 10d. Inside City Limits                            |  |  |  |  |
|                            | • Mary   | ctor           | MD Worcester Ocean City  |  |  | 1 1 Yes 2 □ No                                     |  |  |  |  |
|                            | with the   | Director       | 10e. Street and Number 10f. Zip Code 21842   | 1  | Og. Citizen of What Co                         | ountry?  |  |  |  |  |
|                            | ne 23  | Funerai        | 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S  | pecify Yes or No-                          | 14. Race - Ame                                 |  |  |  |  |  |
| 21215-0036                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than *naturel', or Iteme 23a or 28e-f show any Injury or other traumatic event, the Medical Examinar must be mailified at ance. | þ              | Armed Forces? If Yes, specify Cuban, Mexican, Puert  1 □ Never Married 2 ★ Married  1 □ Yes 2 ★ No  If Yes, Give  Year or Dates:  If Yes, specify Cuban, Mexican, Puert  1 □ Yes 2 ★ No Specify:   | o Rican, etc.)                             | Specify: Wh                                    | · ·  |  |  |  |  |
| 5                          | natur  | etec           | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use natired)   | king                                       | 16b. Kind of Business                          |  |  |  |  |  |
| 12                         | within<br>ene.<br>than   | Completed      | Elementary/Secondary (0-12) College (1-4or 5+)  8th  Cashier   |  | Pastore  | Italian  |  |  |  |  |
|                            | e filed<br>al Hygi<br>other<br>vent,   | BeC            | 17. Father's Name (First, Middle, Last)  18. Mother's Name   |  | Maiden Sumame)                                 |  |  |  |  |  |
| Sla                        | Mente<br>Mente<br>arked  | To             | Carr Mixer C Mirer Small   | an Rifk                                    |  |  |  |  |  |  |
| Maryland                   | d 2 sh<br>th and<br>th and<br>7 is m<br>traum  |                | 19a. Informant's Name/Relationship (Type, Print) husband 19b. Mailing Address (Street and Number or Ru<br>Vincent Giammona 10102 Bonita Drive  |  |  |  |  |  |  |  |
|                            | s 1 an<br>f Heal<br>Item 2<br>other  |                | 20h Place of Disposition (Mame of  | Date                                       | 20a Lagation City of                           | Town State   |  |  |  |  |
| <u><u>E</u></u>            | Pages<br>ment of I<br>ant: If Its<br>ury or o  |                | 4 Bonaton 5 Boths (Openly)   |  | Whitemar                                       |  |  |  |  |  |
| Baltimore,                 | permit. Departimont Import   |                | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jo  Waria January 263 S. Conkling   | seph N.<br>St.Bal                          | Zannino<br>timore,                             | Jr. FH<br>MD 21224                                 |  |  |  |  |
|                            |  |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  | or respiratory arr                         | rest,  | Approximate<br>Interval Between<br>Onset and Death |  |  |  |  |
| a.S.                       | Physician<br>/Medical  |                | Immediate Cause (Final disease or condition resulting in death)  a. Myorardial Internation   |  |  | 14days   |  |  |  |  |
|                            | Examiner   |                | Due to (or as a consequence of):   |  |  |  |  |  |  |  |
| ·                          | D =  | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  |  |  |  |  |  |  |  |
| 1                          | ecute<br>and<br>I-trans  | Examiner       | Cause (Disease or injury that initiated events c: resulting in death) Last  Due to (or as a consequence of):   |  |  |  |  |  |  |  |
| 8760,                      | icate be executed<br>physicien and<br>s the burial-transit   | dical E        | d  |  |  |  |  |  |  |  |
| 9                          | rtificat<br>ng phy<br>s as th  | (a)            | I IF FEMALE:   |  |  |  |  |  |  |  |
| P.O. Box                   | The law requires that the death certifi<br>ate has been signed by the attending<br>page 2 should be detached for use as  | by Physician/M | 23b. Was decedent pregnant in the past 12 months?  1   |  | 23d. Date of de<br>Month                       | livery<br>Day Year                                 |  |  |  |  |
| م:                         | that the hold by a detact  | y Ph           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did to                                | bacco use contribute to                        | o the cause of death?                              |  |  |  |  |
| rds                        | w requires<br>been sign<br>should be   |                | Dinbétes Mellits   | 1□Y  | es 2⊡No 3⊡P                                    | robably Unknown                                    |  |  |  |  |
| Division of Vital Records, | The law re<br>ate has be<br>page 2 sho   | Completed      |  | 24a. Was a autop perfor                    | sy prior to                                    | utopsy findings available completion of cause of   |  |  |  |  |
| /ita                       | ician:<br>sertifici<br>ector,  | Be             | 25. Was case referred to medical examiner?  Hospital: Hospital: 17 September 17 Sep | ath (Check only or                         | ne)  |  |  |  |  |  |
| ð                          | Physical this oral direction   | 1; To          | 27, Manner of Death 28a, Date of Injury 28b, Time of 28c, Injury at  |  | ence 6 Other (Spe<br>ow injury occurred        | ecify)   |  |  |  |  |
| <u>o</u>                   | Attending Physician: r death. ector; After this certific by the funeral director,  | atior          | 1 Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No   |  |  |  |  |  |  |  |
| Divis                      | l or Atte<br>after dea<br>Directo  | Certification; | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | 28f. Location (S<br>City or Tow            | treet and Number or R<br>n, State)             | ural Route Number,                                 |  |  |  |  |
| _                          | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2   | Medical C      | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  | , and due to the d<br>irred at the time, o | ause(s) and manner a<br>date and place, and du | s stated.<br>e to the cause(s)                     |  |  |  |  |
| •                          | vithin to the To the comple  | Me             | 29b. Signature and title of Certifier 29c. License number  |  | 29d. Date signed (Mon                          | th, Day, Year)                                     |  |  |  |  |
|                            |  |                | Attive Julia MD 14/8/3   |  | 1-18-20  | 004  |  |  |  |  |
|                            | 6  |                | 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print),  J. Steve Julian MD 201 Pine Bluff-Road Strips  31. Date filed (Month, Day, Year) 006  32. Registrar's Structure   | ly mo                                      | 21801  |  |  |  |  |  |
| 2                          | Sta<br>Regist  |                | 31. Date filed (Month, Day, Year) 006  | 1  | _  |  |  |  |  |  |

State of Maryland / Department of Health and Mental Hygiene

|  |   |                     |  |  | a. y lair le   | Certific                                 |   |   |   | Reg. No.2   | 06   | 22888   |  |  |
|--|---|---------------------|--|--|----------------|--|---|---|---|---|--|---|--|--|
|  | Physici   | an                  | 1. Decedent's Name (First, Middle, Lest)   |  |                |  |   |   | 2. Dete of De<br>Month                  | Day   | Year   | I. Time of Death  |  |  |
| and the same of th | /Media  |                     | MARIA JUANA VASQUEZ  | JULY   |                |  | 3:05pm  |   |   |   |  |   |  |  |
| 1  | Examin  | ier                 | 4a Fecility Neme (If not institution, give   |  |                |  |   | 4b. City, Town, or  | Locetion of Deat                        | ,   |  |   |  |  |
|  |   |                     | 548 WILSON BRIDGE DR 5. Social Security Number 6. S  |  | e (lín vrs. le | st birthday) If U                        | nder 1 Year                                     | OXEN HILL   | 8. Date of Bir                          | 1.  | GEORGES<br>9 Birthplace                      | State or Foreign  |  |  |
|  | Funeral<br>Director   |                     | Social Security Number  6. Sex Unobtainable  7. Age (In yrs. lest birthday)  94  Yrs.    In Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day, Yes)    Unobtainable   94   Yrs.   94   Yrs.   94   Yrs.   94   Yrs.   94   Yrs.   94   Yrs.   94   Yrs.   94   Yrs.   94   Yrs.   94   Yrs.   94   Yrs.   94   Yrs.   95   Yrs.   95   Yrs.   95   Yrs.   96   Yrs.   96   Yrs.   96   Yrs.   96   Yrs.   96   Yrs.   96   Yrs.   96   Yrs.   96   Yrs.   97   Yr |  |                |  |   |   |   | y, Year)<br>, 1912  | Country)<br>GUATEM                           | e (State or Foreign                                       |  |  |
| 000  | yland<br>F 0  |                     | 10a. Stete 10b. County   |  | 10c. City,     | Town or Location                         | •   |   |   |   | 10d.   | Inside City Limits  |  |  |
| Š,   | e Mar   | ģ                   | MARYLAND PRINCE GEO  |  |                |  | 1 ☐ Yes 2 ☐ No                                  |   |   |   |  |   |  |  |
| 4  | or 28   | je l                | 10e. Street end Number 10f. Zip Code 10g. Citizen of W   |  |                |  |   |   |   |   |  |   |  |  |
| 4  | 238   | <u>a</u>            | 548 WILSON BRIDGE DRIVE #B1 20745  |  |                |  |   |   |   | UNITED ST   |  |   |  |  |
| Maryland 21215-0020  | penim. Togos I study as bound be fined within 72 hours eiter death with the marylar population of Health and Mentel Highene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at office. | by Funeral Director | 11. Maritel Status  1 ☼ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  | 12. Was Decedent E<br>Armed Forces?<br>1 ☐ Yes 2 ☒ N<br>If Yes, Give<br>Yeer or Detes: |                |  | ecedent of F<br>specify Cub<br>s 2 \( \text{No} | dispanic Origin? (S<br>an, Mexican, Puerl<br>Specify: GUA |   | Specify   | e - American I<br>ck, White, etc.<br>" White |   |  |  |
| בי<br>ה  | natura<br>fical   | Completed           | 15. Decedent's Ed<br>(Specify only highest gre   | ucation  |                | 16e. Decedent's U                        | Jsual Occup                                     | pation  | rkina                                   | 16b. Kind of Bu   | usiness/Indust                               | ry  |  |  |
| 2  | 9 5   | ngie                | Elementery/Secondary (0-12)  | College (1-4or 5   | +)             | life. DO NO                              | Tuse retire                                     | during most of word)                                      | King                                    |   |  |   |  |  |
| 7 7  | hygier<br>her th  | S                   | 17. Fether's Neme (First, Middle, Lest)  |  |                | BUSINESS OF                              | NER   | 19 Mother's Nor   | no (First Middle                        | PRIVATE<br>Maiden Surnam  |  |   |  |  |
| aryland z  | d of  | To Be               | MIQUEL VASQUEZ   |  |                |  |   | TOMASA  |   | , maideri Surnani   | 10)  |   |  |  |
| 2  | merk<br>metic   | ۲                   | 19a. Informant's Name/Relationship (7  | [vne Print]  |                | 19b Mailing Add                          | ress (Street                                    | and Number or Ru  |   | er City or Town   | State Zin Co                                 | del   |  |  |
| , Ma   | Ither<br>27 is<br>r trau  |                     | CLEMENCIA RIVAS / DA   |  |                | _  |   | E DRIVE #B  |   | LL, MARY  |  |   |  |  |
| <b>a</b> 3   | of Health<br>item 27 i  | ŀ                   | 20a. Method of Disposition   |  |                | ce of Disposition (                      | Neme of   |   | Date                                    | 20c. Location -   |  |   |  |  |
|  | reges<br>tent of<br>mt: If it   |                     | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify   |  |                | GES WASHING                              |   | -   | 7/16/2006                               | ADELPI  | HI, MARY                                     | LAND  |  |  |
| Baltimore,   | pertm<br>yortsi<br>/ inju   | 1                   | 21. Signature of Funeral Service Licen   |  |                |  |   | ss of Facility  | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |   |  |   |  |  |
| מ מ  | Depe<br>impo<br>any ir  |                     | FLECK FUNERAL HOME 7601 SANDY SPRING RD. LAUREL, MD 2070   |  |                |  |   |   |   |   |  |   |  |  |
|  | hysician<br>/Medical<br>Examiner  | ler                 | shock, or heart failure. List only of<br>Immediate Cause (Final disease or condition<br>resulting in death)  | aMETASTAT  | IC BLA         | DDER CANCE                               |   |   |   |   |  | erval Between<br>set and Death                            |  |  |
| 1  | d ansit   | 튙                   | b. Due to (or as a consequence of):  |  |                |  |   |   |   |   |  |   |  |  |
| tificate be executed   | in being be executed by physician and as the bunel-transit  | edical Examiner     | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury  |  |                |  |   |   |   |   |  |   |  |  |
| os/ou,   | hysici<br>the bu  | dica                | that initiated events resulting in death) Last   | c  | Due to (or a   | is a consequence                         | of):  |   |   |   |  |   |  |  |
| X Silie  | ding p  | <b>S</b> i          |  | d  |                |  |   |   |   |   | 1  |   |  |  |
| 00 49  | attend<br>for us  | ian                 |  | u  |                |  |   |   |   |   |  |   |  |  |
| T.O. BOX   | signed by the attendir<br>be deteched for use   | Physician/          | Part II. Other eignificant conditione co   | ntributing to death bu   | t not result   | ing in the underlyir                     | ig cause giv                                    | ren in Part I.  | 1                                       |   |  | cause of deeth?   |  |  |
| , i  | ed by   |                     | HYPERTENTION   |  |                |  |   |   | 10                                      | Y∎e 2ÃΩNo   | 3 Probabl                                    | y 4 🗌 Unknown   |  |  |
| I RECORDS, P.O. BOX  | peen  | Completed by        |  |  |                |  |   |   | 24a. Was<br>perfo                       | an autopsy<br>rmed?   | availab                                      | autopsy findings<br>sile prior to<br>stion of cause<br>h? |  |  |
|  | page<br>page  | Sol                 |  |  |                |  |   |   | 429                                     | res 2 Kino  | 1 □ Ye                                       | s 2 No  |  |  |
| VILC   | ector   | Be                  | 25. Was case referred to medical examiner?   | Hospital:  |                |  | Oth   | 26. Place of Dea  |   |   |  |   |  |  |
| 5 k  | this c  | -T                  | 1 ☐ Yes 2 ☐ No<br>27. Menner of Death  | 1 L Inpatier   |                | R/Outpatient 3☐                          | DOA Inius                                       | er: 4□ Nursing H  |   | dence 6 Other   |  |   |  |  |
| ם פון  | After<br>fune   | Ę.                  | 1 X Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day)  | Year)          | Injury                                   | 28c. Injur<br>Wor                               | k?<br>Yes 2□No  | 20d. Describe i                         | low injuly occurr   | 90   |   |  |  |
| DIVISION OF VITAL  | s effer death.  I Director: After this certificate has ad in by the funeral director, page 2  | Certification:      | 2 Accident   |  |                |  |   |   |   | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |  |   |  |  |
| To the Hospital  | within 24 hours efter To the Funeral Dire completely filled in b  | edical              | 29a. Certifier (Check only one) 1 ☑ CertifyIng Phy 2 ☐ Medical Example one)  | rsician: To the best of<br>iner: On the basis of<br>and manner state                   | examinatio     | edge, death occur<br>n end/or investigat | ed at the tin                                   | ne, date and place<br>pinion, death occu                  | , and due to the rred at the time,      | cause(s) and ma<br>date and place, a  | nner as stated<br>and due to the             | i.<br>cause(s)  |  |  |
| 70 #   | withi<br>To th  |                     | 29b. Signature and title of certifier  | 111 (  | 0              |  | 29c. Licens                                     | e number  |   | 29d. Date signed  | (Month, Day,                                 | Year)   |  |  |
|  | 1   |                     | trannie ( )  | 16455  | )hu            | wenn)                                    | D2807   | 9   |   | JULY 14, 2  | 2006   |   |  |  |
|  | (00   |                     | 30. Name end address of person who c   | omplet d diuse of de   | ath (Item 2    | Ge) (Type, Print)                        |   |   |   |   |  |   |  |  |
|  | V   |                     |  | 700 BELTSVILI  |                | BELTSVILL                                | E, MD   |   |   |   |  |   |  |  |
|  | Stat  | te                  | 31. Dete filed (Month, Day, Year) JUL 2 1 200  | 3 Registra   | s Signatul     | front.                                   | ,   |   |   |   |  |   |  |  |

DHMH 16 Rev 6/95

EWIS GIOSS 06-04696 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene
1-For State
Amend #7,9,15,16a&b,17 Certificate of Beatth NA BD G858 8703/06 JH UNK UNK Reg No Decedent's Name (First, Middle, Last) 2. Date of Death Time of Deatl Physician/ Day Month 1115 hrs ledical Examiner July 4, 2006 Lewis Gross 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Baltimore City** 1345 James Street 5. Social Security Numberral 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or the 7. Age (In yrs. last birthday **Funeral** Foreign Min Months Davs Hours Director Dec 2, 1952 X M 2 53 Country Connecticut 043-38-4412 Yrs Usual Residence of Decedent 10d Inside City Limits 'n 10a State 10h County 10c. City. Town or Location 1 X Yes 2 No or items 23a or 28a-f show must be notified at once. Baltimore MD after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country 1332 Glyndon Street 21230 **USA** Funeral unk 12. Was Decedent Ever in U.Sunk 13 Was Decedent of Hispanic Origin? (Specify Yes or No. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married Yes f Yes, Give Year Divorced Yes 2 X No specify Widowed 4 Specify: white other than "natural" or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 1/2) 16b. Kind of Business/Industry unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 0 es I and 2 should be filed within of Health and Mental Hygiene unk unk Journeyman HVAC unk 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk event. t Be is marked Herbert Gross Evelyn November Juper 10 Drive Loveland Co. 805.

Street Baltimore: MD 21201 teformant's Name/Relationship (Type, Print Debbie Hinde/Sister O.C.M.E. If item 27 20b. Place of Disposition (Name of cemetery Date crematory or other place) Burial 2 X Cremation 3 Removal from State mportant: Bayview Crematory 8/3/2006 Baltimore, MD ner Specify 22 Name and Address of Facility Connelly Funeral Home of Essex 300 Mace State Anatomy Board 65-by Way Baltimore Street Signature of Funeral Service Licensee Roma Id S W tor, Baltimore, ΜĎ Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** ailure. List only one cause on each line Between Onset and /Medical Death Asphyxia complicating narcotic and cocaine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical item#23a,27,28a-f,perME,g857,7/24/06 TI X UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnance 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was ar 24b Were autopsy findings available autopsy prior to completion of cause of death? performed' ✓ Yes After this certificate Yes 2 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other<sub>4</sub> Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 🗸 Other, Scene 1 V Yes 28d Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c Injury at Work? 27 Manner of Death Certification: Natural Yes 2 x No Pending Fnd 7/4/2006 Fnd 11:00 am unk Director: the Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1345 James Street 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide determined found in house (Specify) 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29c. License number 29d Date signed (Month, Day, Year) 29b Signature and title of certifie O.C.M.E July 5, 2006 30. Name and address of erson who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

**ORIGINAL** 

Deputy Chief Medical Examiner

Registrar

DHMH 17 Rev 1/2001

OCME 2006

State

Jack Titus MD. De

• 2

DHMH 17 Rev 1/2001

State Registrar  Name and address of person who c Theodore M. King, Jr., MD.

31 Date filed (Month, Day, Year)

2. Redistrar's Signature

Assistant Medical Examiner

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 14, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0238 AM Eugene Henry Haynes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. theare 8. Date of Birth (Month, Day, Year) Oct. 31, 1 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1**⊠**M 2□F 87 217-07-8964 1918 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Catonsville Maryland Director 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 5 21228 719 Maiden Choice Lane PV304 United States or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: White Completed by Specify: 3 X Widowed 4 ☐ Divorced Year or Dates "naturai", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical N/Apermit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg
Important: If Item 27 is marked other
any injury or other treumer:
ODCS. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marie Weidenhan James Havnes ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6165 Stevens Forest Road, Columbia, Maryland 21045 Eugene L. Haynes / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UNK 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Embolus ombosis Rightle Immediate Cause (Final disease or condition resulting in death) Physician Mass; /Medical Due to (or as a consequence of): Examiner en Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, signed by the attending physicien by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to geath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 Yes 2 No Division of Vital Hospitel or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 26 ER/Outpatient 3□ DOA ۵ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide To the Hospitel owithin 24 hours at To the Funeral D completely filled in 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of editifie

State Registrar 30. Name and address of person who completes

31. Date filed (Month, Day, Year)

cause of death (Item 23a) (Type

trar's Signature

32. Reg

2006

|                   |  |                  | 1 - For<br>State<br>Registrar   | State of Man   |                           | epartmer<br>Certificat                    |                     |                              | and M                    | R  | eg. No.                    | 006                             | 228                                      | 92            |
|-------------------|--|------------------|---|--|---------------------------|---|---------------------|------------------------------|--------------------------|--|----------------------------|---------------------------------|--|---------------|
|                   | Dhomist  |                  | 1. Decedent's Name (First, Middle, La   | st)  |                           |   |                     |                              |                          | 2. Date of Deat<br>Month                     | h<br>Day                   | Year                            | 3. Time of I                             | Death         |
|                   | Physicia<br>/Medic   |                  | Andre LeRoy   | Ho1  | lland                     |   |                     |                              |                          | July   | 13,                        | 2006                            | 5:29                                     | ам            |
|                   | Examin   |                  | 4a. Facility Name (If not institution, give   | e street and number)   |                           | 4b. City                                  | Town, or            | Location o                   | f Death                  |  | 4c. Co                     | ounty of Death                  | 1  |               |
|                   |  |                  | 12603 Silverbirch Lan   |  |                           | Laur                                      |                     |                              | 0411                     |  |                            | ce Georg                        |  |               |
|                   | Funeral  |                  | 5. Social Security Number 6. S<br>231-82-2477   | Sex 7. Age (h<br>L⊠M 2□F   | n yrs. last bin<br>52     | Yrs. Months                               | r 1 Year<br>Days    | If Under 2<br>Hours          | Min.                     | 8. Date of Birth<br>(Month, Day,<br>07/02/19 | Year)                      | Cou                             | place (State or<br>intry)                | Foreign       |
| 26,               | Director   |                  | Usual Residence of Decedent   |  | 32                        | 713.                                      |                     |                              |                          | 07/02/15                                     | 754                        | virg                            | inia                                     |               |
|                   | land   |                  | 10a. State 10b. County  | 10   | c. City, Town             | or Location                               |                     |                              |                          |  |                            |                                 | 10d. Inside City                         | y Limits      |
|                   | Man,   | to               | Maryland Prince G   | eorges   | Laurel                    |   |                     |                              |                          |  |                            |                                 | 1 X Yes                                  | 2 🗌 No        |
|                   | n the  | irec             | 10e. Street and Number  |  |                           | 10f. Zi                                   | Code                |                              |                          | 1  | 0g. Citizer                | n of What Cou                   | intry?                                   |               |
|                   | th wit   | Funeral Director | 12603 Silverbirch Land  | е  |                           | 2   | 0708                |                              |                          |  | U.S./                      | ۹.                              |  |               |
|                   | dea  | ner              | 11. Marital Status  | 12. Was Decedent Eve<br>Armed Forces?  |                           | 13. Was Dece                              | dent of Hi          | ispanic Orig                 | gin? (Spe                | cify Yes or No-<br>Rican, etc.)              | 14.                        | Race - Amer<br>Black, White     |  |               |
| 9                 | or It  | y Fu             | 1 Never Married 2 Married   | 1 X Yes 2 187  | ′5 <b>-</b> 1980          | 1 ☐ Yes                                   |                     | Specify:                     |                          |  | Sc                         |                                 | ack                                      |               |
| 21215-0036        | within 72 hours after death with the Maryland<br>ene.<br>Then "natural", or Items 23a or 28a-f show<br>he Madical Exambier must be nutified a  | d by             | 3 Widowed 4 Divorced  | Year or Dates:   |                           | 0   |                     |                              |                          |  |                            |                                 |  |               |
| ር<br>ት            | "nat   | Completed        | 15. Decedent's E<br>(Specify only highest gr  | ducation<br>ade completed)   | 16a.                      | Give kind of wo<br>life. DO NOT u         | ork done o          | durina most                  | of workir                | ng   | 16b. Kind                  | of Business/li                  | ndustry                                  |               |
| 7                 | withir<br>ene.<br>then   | щ                | Elementary/Secondary (0-12)   | College (1-4or 5+)   | C+                        | ock Clerk                                 |                     | 7                            |                          |  | CI                         | .: EE . D.                      |  |               |
| ק<br>ס            | filed<br>Hygi<br>other   |                  | 17. Father's Name (First, Middle, Last  | )  |                           | OCK CIEIK                                 |                     | 18. Mothe                    | r's Name                 | (First, Middle, I                            |                            |                                 | partment                                 |               |
| <u>a</u>          | id be<br>ental<br>ked c  | To Be            | Lloyd Holland   |  |                           |   |                     | Pearli                       | ie Hai                   | re   |                            |                                 |  |               |
| Maryland          | shou<br>ind M<br>s mar<br>umat   |                  | 19a. Informant's Name/Relationship (  | Type, Print)   | 19b.                      | Mailing Addres                            | s (Street a         | and Numbe                    | r or Rura                | Route Number                                 | City or To                 | own, State, Zi                  | p Code)                                  |               |
| Σ                 | alth a<br>alth a<br>27 to<br>er tre  |                  | Josie Holland/Wife  |  | 126                       | 03 Silver                                 | birch               | Lane                         | Laure                    | l Maryla                                     | nd 20                      | 0708                            |  |               |
| ğ.                | of He of He itam   |                  | 20a. Method of Disposition  |  | 20b. Place of<br>cemeter  | Disposition (Na                           | me of<br>other plac | e)                           | D                        | ate  | 20c. Locat                 | ion - City or T                 | own, State                               |               |
| Ē                 | Page<br>nent o   |                  | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont |  | Marylan                   | d Nationa                                 | 1 Mem               | Pk. 7                        | 7/17/2                   | 006 L  | aurel                      | , Maryla                        | nd                                       |               |
| Baltimore,        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depermitment of Health and Mental Hygiene. Important: If time 27 is marked other then "natural; or Items 23a or 28a-f show eny injury or other treumatic event, the Madical Examinat must be notified at 20ce.  |                  | 21. Socialists of Funeral Service Lice  | nsee //  |                           | 22. Name a                                | nd Addres           | ss of Facility               | у                        |  |                            |                                 |  |               |
| n<br>—            | 89 E 9 9   | 9 41             | Man E   | Wylli-   |                           | Fleck F                                   | unera               | l Home                       | 7601                     | Sandy Sp                                     | ring F                     | Road La                         | urel, MD                                 | 20707         |
| 1760,             | Physician Medical Examiner and Inspection and Inspe | licai Examiner   | shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, facing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b.  Due to (or as a conductor)  Due to (or as a conductor)  Due to (or as a conductor)  Due to (or as a conductor) | onsequence o              | of):                                      |                     |                              |                          |  |                            |                                 | Interval Betw<br>Onset and D<br>4 Months |               |
| O. Box 68         | res that the death certifical<br>signed by the attending ph<br>be detached for use as th   | Physiclan/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome of p<br>1 ☐ Live birth 2 ☐<br>4 ☐ Pregnant at tim<br>9 ☐ Unknown                              | Fetal death               | 3 □Ectopic p<br>5 □ Other (s <sub>i</sub> |                     | 111                          |                          |  | 23d                        | . Date of deliv<br>Month        |  | ear           |
| <u> </u>          | The law requires that the tee has been signed by the bage 2 should be detache  | by Pt            | Part II. Other significant conditions   | contributing to death but n  | ot resulting in           | the underlying                            | cause give          | en in Part I.                |                          | 23e. Did tob                                 | acco use                   | contribute to                   | the cause of de                          | ath?          |
| Ë                 | w require<br>been sig<br>should b  |                  |   |  |                           |   |                     |                              |                          | 1 □ Ye                                       | s 2 🗆 N                    | lo 3□Pro                        | bably 4 💭 Ur                             | nknown        |
| Records,          | aw re<br>s bee   | Completed        |   |  |                           |   |                     |                              |                          | 24a. Was a                                   | ո 2                        | 4b. Were aut                    | opsy findings a                          | vailable      |
|                   | The tite has   | E                |   |  |                           |   |                     |                              |                          | autops<br>perform                            | ned?                       | death?                          | ompletion of ca                          | use or        |
| <u>E</u>          | Physicien: The fav<br>this certificate has<br>ral director, page 2   | Be C             | 25. Was case referred to medical  |  |                           |   |                     | 26. Place                    | of Death                 | Check only on                                |                            |                                 |  |               |
| >                 | nysic<br>nis ce<br>direc   | To               | examiner?<br>1 ☐ Yes 2 ☐ No   | Hospital: 1 Inpatient  | 2 🗆 ER/Ou                 | tpatient 3 D                              | DA Cthe             | er: 4 □ Nui                  | rsing Hon                | ne 5 ☑ Reside                                | nce 6                      | Other (Speci                    | fy)                                      |               |
| 0                 | ng Pt<br>Iter tt<br>neral  |                  | 27. Manner of Death 1 ★ Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Yo  | 28b. T                    | ime of                                    | 28c. Injury<br>Work |                              |                          | 8d. Describe ho                              |                            |                                 |  |               |
| <u> </u>          | Attending ir death. ector: After by the fune   | catio            | 2 Accident investigation  | n  |                           | М   |                     | Yes 2 1                      |                          |  |                            |                                 |  |               |
| Division of Vital | or Attencafter death<br>Director:<br>in by the   | Certification:   | 3 Suicide 6 Could not be determined   |  | - At home, fa<br>Specify) | rm, street, factor                        | y, office           |                              | 2                        | 8f. Location (St<br>City or Town             |                            | lumber or Rur                   | al Route Numb                            | 19 <i>1</i> , |
|                   | pltel  |                  | COn Continu (X) Continue B  | 7- 11- 1- 14   |                           | d M                                       |                     |                              | 1 -1                     |  |                            |                                 |  |               |
| 1                 | To the Hospitel or Attending Ph<br>within 24 hours atter death.<br>To the Funerel Director: After th<br>completely filled in by the funeral  | edical           | 29a. Certifier 1/ Certifying Pl<br>(Check only 2 Medical Exa  | nysician. To the best of m<br>miner: On the basis of ex<br>and manner stated                                       | amination an              | d/or investigation                        | at the tim          | ne, date and<br>pinion, deat | d place, a<br>th occurre | nd due to the ca<br>d at the time, da        | iuse(s) and<br>ate and pla | d manner as :<br>ace, and due l | stated.<br>to the cause(s)               |               |
| )                 | To the I   | Me               | 29b. Signature and title of portier   |  |                           | 29  | c. License          | e number                     |                          | 2  | 9d. Date s                 | igned (Month,                   | Day, Year)                               |               |
|                   | 1  |                  | > // /// ///  | 1111111  |                           | D   | 08754               |                              |                          |  | July 1                     | 3, 2006                         |  |               |
| i                 | -  | 0.               | 30. Name and address of person who  | complete cau e of deat   | h (Item 23a) (            | Type, Print)                              |                     |                              |                          |  |                            | -                               |  |               |
|                   |  |                  | Thomas A. Bensinger, I  | MD 7525 Green  | way Cir                   | . Dr Gre                                  | enbelt              | , MD 2                       | 0770                     |  |                            |                                 |  |               |
| 1                 | Sta  |                  | 31. Date filed (Month, Day, Year)   |  |                           |   |                     |                              |                          |  |                            |                                 |  |               |
| 1                 | Registr  | 'ar              | JUL 2 1 200   | 6 Have   | JO. 15                    | pover                                     |                     |                              |                          |  |                            |                                 |  |               |

DHMH 17 Rev 1/2001

ORIGINAL

|  | ,              | 1 - For<br>State<br>Registrar  | State of                   | of Marylar  | -                             | artment o  |                              |                      | Mental Hy                           | /giene<br>Reg. No.                       | 2008                                   | 22893   |
|--|----------------|--|----------------------------|---|-------------------------------|--|------------------------------|----------------------|-------------------------------------|--|--|---|
| Physicia   |                | 1. Decedent's Name (First, Middle, Violeta   | V.                         | Hall  |                               |  |                              |                      | 2. Date of D. Month                 |  | 2006 <sup>Year</sup>                   | 3. Time of Death 10:07 a M                              |
| /Medic<br>Examin   |                | 4a. Facility Name (If not institution, Stella Maris  | give street and nu         | ımber)  |                               | 4b. City, Tow<br>Tin                                       | n, or Locat                  |                      | th                                  | 4c.                                      | County of Dea<br>Baltimo               | ith<br>Dre  |
| Funeral<br>Director  |                | 112-01-7159  | 6. Sex<br>1 ☐ M 2 ☐ F      | 7. Age (In yrs.   |                               | If Under 1 Ye<br>Months Da                                 |                              | der 24 Hrs<br>rs Min |                                     | Th Your                                  | 18 I11                                 | thplace (State or Foreign<br>ountry)<br>INDIS           |
| Maryland<br>f ehow   | tor            | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Baltimore Towson   |                            |   |                               |  |                              |                      |                                     |  | 10d. Inside City Limits 1 ☐ Yes 2 💢 No |   |
| with the   | Director       | 10e. Street and Number 918 Breezewick  | Pood                       |   |                               | 10f. Zip Coo   | 286                          |                      |                                     | •  | zen of What C                          | ountry?   |
| permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depermit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Deperment of Heath and Mentall Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumatic event, the Madical Examinat must be notified at once.   | by Funeral     | 11. Marital Status  1 Never Married 25 Marrie 3 Widowed 4 Divorced   | 12. Was Dec<br>Armed F     | 2 ⋈ No<br>ive   | !                             |  | of Hispanic<br>Cuban, Mex    |                      | Specify Yes or N<br>to Rican, etc.) |  | 14. Race - Am<br>Black, Whi            |   |
| within 72 ho<br>liene.<br>r than "natur<br>the Medical.  | Completed      | 15. Decedent<br>(Specify only highes<br>Elementary/Secondary (0-12)  | t grade completed,         | (1-4or 5+)  | (Give                         | dent's Usual Ockind of work do<br>DO NOT use re<br>cher/Si | ne during<br>tired)          |                      | orking                              |  | nd of Business<br>Music                | vIndustry   |
| uld be filed<br>Mental Hyg<br>srked othe   | To Be C        | 17. Father's Name (First, Middle, L<br>John  | ast)<br>Vlahov             | vick  | , - · =                       |  | 18. M                        | other's Na<br>Edna   | me (First, Middle                   |  | Sumame)<br>Stefanc                     | cich  |
| and 2 sho<br>balth and 1 27 le mu  |                | 19a. Informant's Name/Relationsh<br>Albert S. Hall   |                            |   | 918                           | Breezeu  | ick f                        |                      | Towson,                             | MD :                                     | 21286                                  |   |
| Pages 1:<br>lent of He<br>nt: If Iten<br>iry or oth  |                | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp   |                            |   |                               | sition (Name o<br>natory or other<br>EIV. Co               |                              | 7/                   | Date<br>17/06                       |  | cation - City or<br>OWSON ,            |   |
| permit. Departminporte ony inju  |                | 21. Signature of Funeral Service   | nsee Will:                 | iam G. I  |                               |  |                              |                      | uck Tows<br>owson, N                |  | uneral<br>1204                         | Home, Inc.  |
| Control of the property of the private party of the private of the | dicai Examiner | 23a. Part1. Enter the disease, or shock, or heart failure. List of the shock of heart failure. List of the shock of the sh | a. ALZE  Due to  b. Due to | IEIMER S<br>(or as a consection of the consection o | DEMEN quence of): quence of]: |  | dying, such                  | T as cardia          | o or respiratory t                  |  |  | Approximate<br>Interval Between<br>Onset and Death      |
| Physician: The law requires that the death certificate this certificate has been signed by the attending physial director, page 2 should be detached for use as the  | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown  | 1 Live                     | utcome of pregn<br>birth 2 Fet<br>nant at time of a<br>nown   | al death 3                    | Ectopic pregna<br>Other (specify                           |                              |                      |                                     | 2  | 23d. Date of de<br>Month               | elivery<br>Day Year                                     |
| w requires that the decomposition of the analysis and the analysis should be detached to   | Ď              | Part II. Other significant condition   | ns contributing to         | death but not re  | sulting in the u              | nderlying cause  | given in F                   | art I.               | 1                                   |  |  | o the cause of death?                                   |
| The law recate has be page 2 she   | Completed      |  |                            |   |                               |  |                              |                      | perf                                | s an<br>opsy<br>formed?<br>2 <b>X</b> No | 24b. Were a prior to death?            | utopsy findings available completion of cause of s 2 No |
| sician<br>certifi<br>irector   | o Be           | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  | Hospital:                  | Inpatient 2   | ER/Outpatier                  | nt 3 DOA   | Other                        |                      | eath (Check only                    |  | VOther (See                            | ecify) HOSPICE  |
| E of each  | D: T           | 27. Manner of Death  1 Matural 5 Pendin 2 Accident investig 3 Suicide 6 Could n  | g 28a. Date (Mor           | of fnjury<br>nth, Day Year)   | 28b. Time o<br>Injury         | M 28c. I   | njury at<br>Work?<br>1 🗌 Yes |                      | 28d. Describe                       | how injur                                | y occurred                             |   |
| ital or At<br>urs after d<br>ral Direct  | Certificati    | 4 Homicide determi   | ined 286. Place build      | e of Injury - At h  | ify)                          |  |                              |                      | City or To                          | own, State                               | )                                      | Bural Route Number,                                     |
| To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune fune.  | Aedical        | (Check only 2 Medical I  |                            |   |                               | vestigation, in r  | ny opinion,                  | death occ            |                                     | , date and                               | place, and du                          | e to the cause(s)                                       |
| T with   | Σ              | 29b. Signature and title of certifier  |                            |   |                               | 296. Lie   | ense num                     | 72                   | 5                                   | ∠9a. Dat                                 | 9 signed (Mon                          |   |
| 67   |                | 30. Name and address of person of DR. TARIO MAHM   |                            | use of death (Ite   |                               |  | TIMO                         | NIUM                 | , MD 210                            | 93                                       |  |   |
| Sta<br>Regist  |                | 31. Date filed (Month, Day, Year)  JUL 2 1   | 32.                        | bgistrar's Sign   |                               | este   |                              |                      |                                     |  |  |   |

DHMH 17 Rev 1/2001

JULY 15, 2006 10:0/ a.m.

VIOLETA HALL

|                     |  |                | 1 - For<br>Stata<br>Registrar  | State of N                             | /larylar           | nd / Depa<br><i>Cei</i>       | artmer<br>rtificat      | nt of H                   | ealth ar<br>D <i>eath</i>      | nd Me                 | ental Hy                     | giene<br>Reg. No |                            | 22                               | 894                                     |
|---------------------|--|----------------|--|--|--------------------|-------------------------------|-------------------------|---------------------------|--------------------------------|-----------------------|------------------------------|------------------|----------------------------|----------------------------------|---|
|                     |  |                | Decedent's Name (First, Middle, Last)     2. Date of Death                   |  |                    |                               |                         |                           |                                |                       |                              |                  | of Death                   |                                  |   |
|                     | Physici<br>/Medio  |                | MILLIARD WITTBUR HODGES  |  |                    |                               |                         |                           |                                |                       | y Year<br>2006               | 7:0              | 5. A M                     |                                  |   |
|                     | Examir   | ier            |  |  |                    |                               |                         |                           |                                | . County of De        | ath                          |                  |                            |                                  |   |
|                     |  |                | 1868 SNYDERSBU   |  | ,,                 |                               |                         |                           | NSTE                           |                       |                              |                  | CARROL                     |                                  |   |
| 0                   | Funeral<br>Director  |                | 5. Social Security Number 6. S   | 96X<br>1√2√M 2□F                       | ige (in yrs.<br>82 | last birthday) Yrs.           | Months                  | r 1 Year<br>Days          | If Under 24<br>Hours           | Min.                  | B. Date of Bir<br>(Month, Da | ay, Year,        | 1 (                        | rthplace (State<br>ountry)       |   |
|                     |  |                | 218-18-0421 Usual Residence of Decedent                                      |  | 02                 | 4                             |                         |                           |                                |                       | 7/10/                        | 192              | 4 MAI                      | RYLAND                           | )                                       |
|                     | yland  |                | 10a. State 10b. County   |  | 10c. Cit           | ty, Town or Lo                | cation                  |                           |                                |                       |                              |                  |                            | 10d. Inside                      | City Limits                             |
|                     | Pa-f   | cto            | MD CARRO   | LL                                     | V                  | VESTMI                        | NST                     | ΣR                        |                                |                       |                              |                  |                            | 1 □ Ye                           | es 2∏No                                 |
|                     | ath with the Marylan<br>23a or 28a-1 show  | Director       | 10e. Street and Number   |  |                    |                               | 10f. Zip                | Code                      |                                |                       |                              | 10g. Ci          | tizen of What C            | ountry?                          |   |
|                     | ath w  | - a            | 1868 SNYDERSBU   |  |                    |                               |                         | 1157                      |                                |                       |                              |                  | SA                         |                                  |   |
|                     | itam<br>itam   | nue            | 11. Marital Status   | 12. Was Deceden                        | ?                  | .S. 13. \                     | Vas Dece<br>f Yes, spe  | dent of His<br>cify Cubar | spanic Origin<br>1, Mexican, F | n? (Spec<br>Puerto Ri | rfy Yes or No<br>ican, etc.) | )-               | 14. Race - Am<br>Black, Wh |                                  |   |
| 36                  | irs aft  | by Funeral     | 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced                       | 1X Yes 2 If Yes, Give<br>Year or Dates |                    | т                             | 1 🗌 Yes                 | 2X No                     | Specify:                       |                       |                              |                  | Specify: WI                | HITE                             |   |
| Š                   | 72 hours after death with the Maryland<br>natural', or itams 23s or 28s-1 ehow<br>itsal Examiner must be notified at   | ted            | 15. Decedent's E   | ducation                               |                    | 16a. Deced                    |                         |                           |                                |                       |                              | 16b. K           | and of Business            |                                  |   |
| 2                   | within 7<br>ene.<br>than "n<br>the Med   | Completed      | (Specify only highest gr. Elementary/Secondary (0-12)                        | ade completed)  College (1-4o          | 5+)                | (Give                         | kind of wo<br>DO NOT u  | rk done d<br>se retired)  | uring most o                   | f working             | 7                            |                  |                            |                                  |   |
| 7                   | filed wil<br>Hygien<br>other th  | Con            | 12   | 2                                      |                    | AR                            | EA E                    | NGI                       | VEER                           |                       |                              | RA               | ILROAD                     | )                                |   |
| nd                  | 9 E 5 5  | Be             | 17. Father's Name (First, Middle, Last                                       | )<br>M MILLAF                          | ים דוכ             | DCEC                          |                         |                           |                                |                       | First, Middle                |                  | -/                         |                                  |   |
| Z                   | 2 should to and Ment ie marked sumatic   | 70             |  |  | то пс              |                               |                         |                           |                                |                       | MAY D                        |                  |                            |                                  |   |
| Maryland 21215-0036 | s 1 and 2 should<br>f Heelth and Mer<br>frem 27 ie marke<br>other traumatic  |                | 19a. Informant's Name/Relationship (   |  |                    |                               |                         |                           |                                |                       |                              |                  | or Town, State,            |                                  |   |
| a)                  | of Heelth of Hem 27 is rother tra  |                | KATHLEEN M. RO 20a. Method of Disposition                                    | HE -DAUG                               |                    | L 1868<br>Place of Dispo      |                         |                           | BURG                           | RD<br>Dat             |                              |                  | NSTER ,                    |                                  | 157                                     |
| Baltimore,          | permit. Pages<br>Department of the important: if its any injury or of once.  |                | 1 □ Burial 2 ② Cremation 3 □   |  | _   0              | emetery, cren                 | natory or c             | ther place                |                                |                       |                              |                  | ESVILL                     |                                  |   |
| Ħ                   | artme<br>ortan<br>injury   |                | □ Donation 5 □ Other (Special 21. ignation of / in al 3 am e Licer           |  | чнп                |                               |                         |                           |                                |                       |                              |                  |                            |                                  |   |
| Ba                  | Depa<br>Impo<br>any i  |                | k Will   |  |                    |                               |                         |                           |                                |                       |                              |                  | NERAL<br>CER, M            |                                  | <i>-</i> 7                              |
|                     |  |                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only  | plications that cause                  | d the deat         | h. Do not ente                | er the mod              | le of dying               | , such as ca                   | rdiac or              | respiratory a                | rrest,           | LEK, M                     | Approxim                         | ate                                     |
|                     | Physician  | 8 0            | Immediate Cause Final disease or condition                                   | one cause on each                      | iine.              | _                             | neum                    |                           |                                |                       |                              |                  |                            | Onset and                        | d Death                                 |
|                     | /Medical   |                | resulting in death)  | a<br>Due to (or a                      | s a conseq         |                               | , , ,                   | 10171                     |                                |                       |                              | _                |                            | 3 MOI                            | 11/15                                   |
|                     | Examiner   |                | Sequentially list conditions,  | b                                      |                    |                               |                         |                           |                                |                       |                              |                  |                            |                                  |   |
|                     | pe is  | Examiner       | d any, leading to inmediate cause. Enter Underlying Cause (Disease or injury | Dua to (or a                           | B & CONSEQ         | uarida of);                   |                         |                           |                                |                       |                              |                  |                            |                                  |   |
|                     | and<br>F-tran  | xam            | that initiated events resulting in death) Last                               | c Due to (or a                         | ÷ a consoc         | uance of):                    |                         |                           |                                |                       |                              |                  |                            |                                  |   |
| 8760,               | cate be executed<br>physician and<br>the burial-transit  | <u>е</u><br>Ш  |  |  | <i>-</i> 4 0011004 | 23.100 01).                   |                         |                           |                                |                       |                              |                  |                            |                                  |   |
| 687                 | tificate<br>ig phys<br>as the  | edical         |  | _ d                                    |                    |                               |                         |                           |                                |                       |                              |                  |                            |                                  |   |
| Вох                 | eath certifi<br>attending<br>for use as  | 2              | IF FEMALE:<br>23b. Was decedent pregnant                                     | 23c. If yes, outcom-                   |                    |                               |                         |                           |                                |                       |                              |                  | 23d. Date of de            | livery                           |   |
| m                   | death<br>e atte  | Cla            | in the past 12 months?<br>1 ☐ Yes 2 ☐ No                                     | 1☐Live birth<br>4☐Pregnant a           |                    |                               | Ectopic pr<br>Other (sp |                           |                                |                       |                              |                  | Month                      | Day                              | Year                                    |
| P.0                 | thet the death<br>led by the atter<br>detached for u   | Physician/Me   | 9 Unknown  | 9□ Unknown                             |                    |                               |                         |                           |                                |                       |                              |                  |                            |                                  |   |
| ś                   | 50 00  | þ              | Part II. Other significant conditions of                                     | ontributing to death                   | but not resi       | ulting in the un              | derlying c              | ause give                 | in Part I.                     |                       | 23e. Did to                  | obacco i         | use contribute to          | the cause of                     | death?                                  |
| Vital Records,      | w requir<br>been si<br>should  | Completed      |  |  |                    |                               |                         |                           |                                |                       | 101                          | es 2,            | <b>2</b> No 3 □ P          | robably 4                        | ]Unknown                                |
| Sec                 | a law  | ם              |  |  |                    |                               |                         |                           |                                | _                     | 24a. Was<br>autop            |                  | 24b. Were a                | utopsy findings<br>completion of | s available cause of                    |
|                     | cate   | වි             |  |  |                    |                               |                         |                           |                                |                       | perfo                        | rmed2<br>2 No    | death?                     |                                  |   |
| <u> </u>            | Physician: this certific   | Be             | 25. Was case referred to medical examiner?                                   | Hospital:                              |                    |                               |                         | Other                     |                                | Death (0              | Check only o                 | ne)              |                            |                                  |   |
| ō                   | Phys<br>this<br>ral dii  | <u>د</u>       | 1 Yes 2 No  27. Manner of Death  | 1 ☐ Inpati                             |                    | ER/Outpatient<br>28b. Time of |                         |                           | 4 🗆 Nursir                     |                       |                              |                  | 6 □Other (Spe              | cify)                            |   |
| o                   | ding<br>h.<br>After  | to             | 1 Natural 5 Pending 2 Accident investigation                                 | (Month, Da                             | ay Year)           | Injury                        | M                       | 8c. Injury<br>Work?       | at<br>es 2∐No                  |                       | d. Describe t                | iow injur        | y occurred                 |                                  |   |
| Division of         | Attending r death. sctor: After by the funer   | flca           | 3 ☐ Suicide 6 ☐ Could not b  | 28e. Place of In                       | jury - At ho       | me, farm, stre                |                         |                           |                                |                       | f. Location (5               | Street an        | d Number or R              | ral Route Nu                     | mher                                    |
| á                   | aior A<br>s effer<br>i Dire<br>d in by   | Certification; | 4  Homicide determined   | building, e                            | tc. (Specify       | 1)                            | ,                       |                           |                                |                       | City or Tox                  | m, State         | )                          |                                  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
|                     | To the Hospital or Attending Physician: The la within 24 buous elter death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2 |                | 29a. Certifier  (Check only 2 Medical Exam                                   | ysician: To the best                   | of my kno          | wiedge, death                 | occurred                | at the time               | , date and p                   | lace, and             | d due to the                 | cause(s)         | and manner as              | stated.                          |   |
|                     | To the H<br>within 24<br>To the Fi<br>complete   | Medical        | one)   | niner: On the basis of<br>and manner s | or examinai        | ion and/or inv                | estigation,             | ın my opi                 | nion, death o                  | occurred              | at the time,                 | date and         | place, and due             | to the cause(                    | s)                                      |
|                     | To the<br>Within<br>To the   | 2              | 29b. Signature and title of certifier  | Aml m.                                 | P/M                | 2                             | 29c                     | . License                 |                                |                       |                              | 29d. Dat         | e signed (Mont             |                                  |   |
| al                  | 1  |                |  | 116                                    |                    |                               |                         | 000                       | 5999                           | 5                     |                              | ٦,               | 11 2012                    | 100Ce.                           |   |
| h                   | 1  |                | 30. Name and address of person who   | completed cause of                     | death (Item        | 23a) (Type, F                 | Print)                  | rive                      | 357                            | عــــى،               | 5min                         | < 10             | · Mr                       | 7115                             | ,                                       |
|                     | Sta  | 20             | 31. Date filed (Month, Day, Year)  | 32. <b>Fig</b> aist                    | rar's Signal       | ture                          |                         | 11                        | ) ~ (                          | V .                   | 7/17/11/1                    | 2/               | 1-1-                       | 211)                             | /                                       |
|                     | Sta<br>Registr   | -              | JUL 2 1 2  | 006                                    | ue )               | J. De                         | 2000                    | P                         |                                |                       |                              |                  |                            |                                  |   |

06-05119 Lynn Harris

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death Month Day July 17, 2006 Medical Examiner 0325 hrs Lynn M. Harris 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore 5. Social Security Number If Under 1 Year Age (In yrs. last birthday If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days oreign Director Months Hours Mir 220-94-9630 1 M 2X F 42 4-11-1964 Country) Canada Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Yes 2 X No MD Baltimore Catonsville death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Bloomsbury Avenue notified 21228 USA 23а Funeral 11. Marital Statu 12 Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black must be Armed Forces? 1 Never Married 2 X Married White etc. Yes permit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygiena. I hoporant: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examiner. f Yes, Give Year Widowed Divorced Specify White Yes 2 X No specify ₽ 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Garten Desjardins Marie Paule Mayer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin C. Harris -Husband 105 Bloomsbury Avenue, Baltimore, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 X Cremation 3 crematory or other place) Removal from State Donation 5 Other Specify 7-21-06 | Baltimore, MD Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton Funeral Home 2134 Willow Spring Road, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Alcohol and combined drug (Trazadone and oxycodone) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions ner if any, leading to immediate Due to (or as a consequence of) cause. Enter underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Sa g physician a X UNPENDED AMENDED item#23a,27,28a-f,perME,g858.8/10/06 TT Amend item#4c /sician/Medi Division of Vital Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month 2 Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy After this certificate has performed? ✓ Yes 2 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other ို 1 V Yes 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 1 Yes 2 No 5 Pending 24 hours after death Fuueral Director: Fnd 7/17/2006 Fnd 3:25 am 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 XX Could not be Catonsville. MD Bloomsbury Ave determined (Specify) at residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started within 2 To the 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c License number 29d Date signed (Month, Day, Year) O.C.M.E. July 17, 2006 Theodore M. King, Jr., MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Day, Year) 32. Registrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Registra

2006

|                     |   |                   | 1- State Amend Item Registrar   |   | and / Dep<br>, C857, Ce | 721706ah<br>ertificate of                | dealth and M<br>Death                           | R  | eg. No. 💪 U U 🗓                        | 2289   |  |  |  |
|---------------------|---|-------------------|---|---|-------------------------|--|---|--|--|--|--|--|--|
| П                   | Physic  | an                | Decedent's Name (First, Middle, Last  |   |                         |  |   | <ol><li>Date of Deat<br/>Month</li></ol>   | Day Yeer                               | 3. Time of Death                                   |  |  |  |
|                     | /Medi   |                   | Joseph G. Iaconi  |   |                         | T  |   | June 27                                    |  | 7:00 AM M  |  |  |  |
|                     | Examir  | ner               | 4a. Fecility Name (If not institution, give   |   |                         |  | or Location of Death                            |  | 4c. County of Dea                      |  |  |  |  |
|                     |   |                   | 5 Timbershed Cou  5. Social Security Number 6. Se   |   | yrs. last birthday      | Freel:                                   |   | 8 Date of Birth                            | Baltim                                 |  |  |  |  |
| r                   | Funeral<br>Director   |                   |   | ŽM 2□F 7  |                         | Months Days                              | Hours Min.                                      | 8. Date of Birth<br>(Month, Day,<br>Mar 1, | 1932 Mar                               | thplace (State or Foreign<br>ountry)<br>yland      |  |  |  |
|                     | 72 hours after death with the Maryland<br>natural; or Itams 23a or 28a-1 show<br>dical Exandrat must be notified at |                   | 10a. State 10b. County  | 100   |                         |  |   | 10d. Inside City Limits                    |  |  |  |  |  |
|                     | Mar Mar   | to                | MD Baltimo  | ore   | Freela                  | and                                      |   |  |  | 1 ☐ Yes 2 ☐ No                                     |  |  |  |
|                     | h the   | řě                | 10e. Street and Number  |   |                         | 10f. Zip Code                            |   | 1  | 0g. Citizen of What Co                 | ountry?  |  |  |  |
|                     | th will   | Funeral Director  | 5 Timbershed Court 21053  |   |                         |  |   |  | USA                                    |  |  |  |  |
|                     | ams rdea  | Iner              | 11. Marital Status  | 12. Was Decedent Ever<br>Armed Forces?          | in U.S. 13.             | Was Decedent of h                        | Hispanic Origin? (Spean, Mexican, Puerto        | ecify Yes or No-<br>Rican, etc.)           | 14. Race - Ame<br>Black, Whit          |  |  |  |  |
| Š                   | or It   |                   | 1 Never Married 2 Married   | 1 XYes 2 No                                     |                         | 1 ☐ Yes 2 ☒ No                           |   |  | Specify: Wh                            |  |  |  |  |
| ğ                   | urai  | d by              | 3 ☐ Widowed 4 MDivorced Year or Dates: 152-56   |   |                         |  |   |  |  |  |  |  |  |
| Ϋ́                  | n 72<br>• nat   | Completed         | 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)  |   |                         |  |   |  | ing 16b. Kind of Business/Industry unk |  |  |  |  |
| Maryland 21215-0036 | within<br>iene.<br>than   | Ę.                | Elementary/Secondary (0-12)   | College (1-4or 5+)<br>4                         |                         | draftsman                                |   |  |  |  |  |  |  |
| 0                   | e filed<br>il Hygie<br>other<br>vent, II  |                   | 17. Father's Name (First, Middle, Last)   | <del></del>                                     |                         | urai tsillali                            | 18. Mother's Name                               | (First, Middle, M                          | Maiden Sumame)                         |  |  |  |  |
| a                   | ld be<br>ental<br>ked c   | To Be             | Frank Iaconi  |   |                         |  | Anna I  | eGennar                                    | 0                                      |  |  |  |  |
| 2                   | 2 should be and Mental is marked o  | -                 | 19a. Informant's Name/Relationship (T)  | vpe, Print)                                     | 19b. Mail               | ing Address (Street                      | and Number or Rura                              | il Route Number,                           | City or Town, State, 2                 | Zip Code)  |  |  |  |
| Š                   | 27 lith a   |                   | Donna J. Mabe/daug  | hter  | 5 Ti                    | imbershed                                | Court Fre                                       | eland, 1                                   | MD 21053                               |  |  |  |  |
| je<br>G             | ges 1 ar<br>t of Hea<br>if item<br>or othe  |                   | 20a. Method of Disposition  |   | b. Place of Disp        | osition (Name of<br>ematory or other pla |   | ate  | 20c. Location - City or                | Town, State  |  |  |  |
| Ë                   | Pages<br>nent of<br>int: If it<br>iry or o  |                   | 1 ☐ Burial 2 ☐ Cremation 3 ☐ F  1 ☑ Donation 5 ☐ Other (Specify)  |   |                         |  |   |  |  |  |  |  |  |
| Baltimore,          | permit. Pag<br>Department<br>Important: I<br>any injury o   |                   | 21. Signature of FAngret Service Ligans   | Pleasant Reasant                                | 2                       | 2. Saratre Adar<br>Baltimon              |   | rd 655 V<br>201                            | V. Baltimor                            | re Street  |  |  |  |
|                     | 影   |                   | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only o  |   | leath. To not en        | er the mode of dyin                      | ng, such as cardiac o                           | r respiratory arre                         | est,                                   | Approximate<br>Interval Between<br>Onset and Death |  |  |  |
|                     | ate be executed /Medical Examiner and physician and physician and the burial-transit                                | Examiner          | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hyprothat intitated events resulting in death) Last | faila   | sequence of):           | Hriv                                     | ė.  |  |  |  |  |  |  |
| P.O. Box 68/60,     | death certific<br>e attending p<br>ed for use as  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | dd  | etal death 3            | □Ectopic pregnancy                       | ,   | 711  | 23d. Date of deli<br>Month             | ivery<br>Day Year                                  |  |  |  |
| -                   | law requires that the<br>as been signed by th<br>2 should be detache  | by                | Part II. Other significant conditions co  | ntributing to death but not                     | en in Part I.           |  | d tobacco use contribute to the cause of death? |  |  |  |  |  |  |
| Vital Records       | The<br>ate ha   | Completed         |   |   |                         |  |   | 24a. Was an autopsy perform                | / prior to d                           | topsy findings available completion of cause of    |  |  |  |
| ı ta                | Physician: Th<br>this certificate<br>ral director, pag  | Be                | 25. Was case referred to medical examiner?  |   |                         |  | 26. Place of Death                              | (Check only one                            | 9)                                     |  |  |  |  |
| 0                   | Physic<br>this c  | ၉                 | 1 ☐ Yes 2 ☑ No  | lospital:                                       |                         |  | 4   Nursing Hor                                 |  | nce 6 Other (Spec                      | city)  |  |  |  |
| Ĕ                   | ing P   | on:               | 27. Manne   | 28a. Date of Injury<br>(Month, Day Yea          | r) 28b. Time o          | Wor                                      |   | Describe ho                                | w injury occurred                      |  |  |  |  |
| Division            | ol or Attending P<br>after death.<br>Director: After<br>d in by the funera  | Certification:    | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined   | 28e. Place of Injury -                          | At home, farm, st       |  | Yes 2 □No                                       | 28f. Location (Str                         | eet and Number or Ru                   | ral Route Number,                                  |  |  |  |
| <u>ה</u>            | 0 = 5 =   |                   |   | building, etc. (Sp                              |                         | th occurred at the tir                   | me date and place a                             | City or Town,                              |  | otatad   |  |  |  |
|                     | To the Hospitel within 24 hours a To the Funerel Completely filled  | edical            | (Check only 2 Medical Exemi   | ner: On the basis of exam<br>and manner stated. | nination and/or in      | nvestigation, in my o                    | pinion, death occurre                           | ed at the time, da                         | te and place, and due                  | to the cause(s)                                    |  |  |  |
| ,                   | To t<br>To t  | M                 | 29b. Signature and title of certifier   | MU  | <b>&gt;</b>             | 29c. Licens                              |   |  | d. Date signed (Month                  |  |  |  |  |
|                     |   |                   | 30. Name and address of person who co   | empleted clause of death (                      | Item 23a) (Type         | Print)                                   | unto 208  | Towser                                     | 6/29/0]<br>MD 212                      | ey.  |  |  |  |
|                     | Sta   | ite               | 31. Date filed (Month, Day, Year)   | 32. Pagistrar's S                               | ignature                | 1 41                                     |   |  |  |  |  |  |  |

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|                                |  |                | State of Maryland / Department of Health and M  | •  |                                |  |
|--------------------------------|--|----------------|---|--|--------------------------------|--|
|                                |  | 1              | 1 - State Cortificate of Death  | Reg.   | 7 UUD                          | 22897  |
|                                |  |                | 1. Decedent's Name (First, Middle, Last)  | 2. Date of Death                             | NO.                            | 3. Time of Death                                   |
| . 7                            | Physicia   |                | Janie Wilson Johnson  | $\frac{\text{Month}}{\text{July 14}}$        | Day Year                       | 7:00 P <sup>M</sup>                                |
|                                | /Medic<br>Examin   |                | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  |  | 4c. County of Deat             |  |
| 4                              |  |                | Crofton Convalescent Rehab Center Crofton   | A  | nne Arun                       |  |
| 7                              | Funeral  |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 ☐ M 2 ☑ F 1 ☐ M 2 | 8. Date of Birth<br>(Month, Day, Ye          | ar) 9. Birti                   | nplace (State or Foreign untry)                    |
| Z.                             | Director   | -              | 226-12-4745   | June 12,                                     | 1896                           | SC   |
|                                | land<br>ow   |                | 10a. State 10b. County 10c. City, Town or Location  |  |                                | 10d. Inside City Limits                            |
|                                | Many<br>a-feh  | į              | MD Anne Arundel Crofton   |  |                                | 1 XYes 2 ☐ No                                      |
|                                | or 28,   | Director       | 10e. Street and Number 10f. Zip Code  | 10g.   | Citizen of What Co             | untry?   |
|                                | 23a  | rai            | 2131 Davidsonville Road 21114   |  | USA                            |  |
|                                | er de  | Funeral        | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto   | ecify Yes or No-<br>Rican, etc.)             | 14. Race - Ame<br>Black, White |  |
| 36                             | ir, or   | by F           | 1  Never Married 2 Marned 1  Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:   |  | Specify: B1                    | .ack   |
| 9                              | be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23a or 28a-f show event, the Medical Exact arms the contilled at  |                | 15. Decedent's Education  16a. Decedent's Usual Occupation  (Cinc kind of work does develop most of work)   | 16b  | . Kind of Business/            | Industry   |
| 215                            | thin 7   | Completed      | (Specify only highest grade completed)  [Give kind of work done during most of working life. DO NOT use retired]  [Give kind of work done during most of working life. DO NOT use retired]  |  | 15                             | _  |
| 21                             | filed w<br>Hygien<br>other th  |                | 8 Seamstress  | (First, Middle, Maid                         | elf Emplo                      | yed  |
| Baltimore, Maryland 21215-0036 | ntal H<br>od ot  | Be             |   | Armstron                                     |                                |  |
| Ž                              | ges 1 and 2 should be<br>t of Health and Mental<br>If item 27 is marked o  | P<br>P         | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura   | al Route Number, Ci                          | ty or Town, State, 2           | lip Code)  |
| $\mathbf{z}$                   | 01 00 00   |                | Karen Fleming/Grandniece 200 Towsontown Court   | #504 Tow                                     | son. MD                        | 21204  |
| re,                            | Pages 1 and 2<br>nent of Health<br>ant: If item 27 i   | 1              | 20a. Method of Disposition 20b. Place of Disposition (Name of   |  | . Location - City or           | Town, State  |
| m                              | permit. Page<br>Department of<br>Important: If<br>any njury or<br>once.  |                | 4 Donation Other (Specify) Church Cemetery /-21/  |  | orgetown,                      | SC   |
| alt                            | permit.<br>Departr<br>Importa<br>any nju   |                | 21. Sign Ture of Funeral Service Licensee 22. Name and Address of Facility W1.  |  |                                |  |
|                                | 20E 2 9  |                | Lennis Willman 130 Merriman Road,   |  |                                | Announce   |
|                                |  |                | 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  | or respiratory arrest,                       |                                | Approximate<br>Interval Between<br>Onset and Death |
| 7                              | Physician /Medical   |                | Immediate Cause (Final disease or condition a. Atherosclenotic Heart I  | ) is ear                                     | ~                              | yours  |
|                                | Examiner   |                | Due to (or as a consequence of):  Failung to Thrive   |  |                                | years<br>years                                     |
|                                |  | er             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | •  |                                | 0  |
|                                | nd   | Examin         | that initiated events C.  |  |                                | years  |
| 760,                           | te be executed<br>ysician and<br>e burial-transit  | ŭ              | resulting in death) Last Due to (or as a consequence of):   |  |                                | •  |
| 687                            | death certificate be executed a attending physician and dior use as the burial-transit   | dicai          | d   |  |                                |  |
| X 6                            | certifi<br>ding<br>use as  | /We            | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy   |  | 23d. Date of del               | ivery  |
| Box                            | death<br>a atter<br>d for u  | Physician/Medi | in the past 12 months?  1 Vee 3 MNo 4 Pregnant at time of death 5 Other (specify)   |  | Month                          | Day Year   |
| P.0                            | that the de<br>led by the a<br>detached t  | hys            | 9 ☐ Unknown   |  |                                |  |
|                                | 9 P 9  | by F           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | .1                             | the cause of death?                                |
| ord                            | w requir<br>been si<br>should  | ted            |   | 1 Tes  | ^                              | obably 4 Unknown                                   |
| of Vital Records,              | e law<br>has to  | Completed      |   | 24a. Was an autopsy performed                | prior to                       | topsy findings available completion of cause of    |
| a                              |  |                | 25. Was case referred to medical 26. Place of Death   | 1□ Yes 2                                     |                                | 2 🗆 No   |
| Ν                              | Physician:<br>rthis certific<br>ral director,  | o Be           | examiner?   | n <i>(Check only one)</i><br>me 5□ Residence | a 6 ∏Other (Spe                | cify)  |
|                                | g Phy<br>erthi   | 1              | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at   | 28d. Describe how i                          |                                |  |
| ion                            | Attending or death. sctor: After by the fune   | atio           | 2 Accident investigation M 1 Yes 2 No   |  |                                |  |
| Division                       | tal or Attending Pt<br>is after death.<br>st Dirsctor: After th<br>ed in by the funeral  | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | 28f. Location (Stree<br>City or Town, S      |                                | ural Route Number,                                 |
| Ω                              | Hospital of the hours at Funers! Distributed is the hours at the hours |                | 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,   | and due to the caus                          | a(s) and manner as             | ctated   |
|                                | To the Hospital or Atterville 24 hours after de To the Funeral Directo completely filled in by the   | Medical        | (Check only one) and manner stated.   | ed at the time, date                         | and place, and due             | to the cause(s)                                    |
|                                | To the within 2 To the complet   | Se Se          | 29b. Signature and title of certifier 29c. License number   | -  | Date signed (Mont              |  |
|                                | /  |                | * Kakush Ovo/191 MD D20108  | 5  | July 18                        | 2006   |
|                                | 1  |                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  |                                |  |
|                                | <b>n</b>   | ]              | Delegan Arore M.D. $1/2000$ 0-11 $\cdot$ $\pm$ $\cdot$ $\pm$ $\cdot$  |  |                                |  |
| 100                            | 5<br>Sta   | ate            | Rakesh Arora, M.D. 14300 Gallant Fox Ln., Bowing JUL 2 1 2006   | e, MD 207                                    | 15                             |  |

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>D</sup>2006 July 19, 8:25 AM Physician Edgar Jack Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery Months Days Hours Min. 8. Date of Birth (Months Days Hours Min. 097077124) 9. Birthplace (State or Foreign FL 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□F 725-01-2521 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show The Medical Examiner must be notified at MD 1 ☐ Yes 2 No Montgomery Silver Spring Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11901 Georgia Ave 20902-USA Iteme 23a Funeral fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 12€1Yes 2 □ No WWII Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: δ Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done d life. DO NOT use retired) Keystone Steel other then Elementary/Secondary (0-12) Cotlege (1-4or 5+) Ironworker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy
Important: If Item 27 Is marked oth
any Injury or other traumatic event
popes. Be Samuel Johnson Lizzie Glover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Nadine Edmonds Johnson/Wife 11901 Georgia Ave Silver Spring, MD 20902-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Jul 27 20c. Location - City or Town, State to Burial 2 ☐ Cremation 3 ☐ Removal from State , Pennsylvania Holy Cathedral 2006 4 ☐ Donation — 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal Failure /Medical Due to (or as a consequence of) Examiner Urosepsis Sequentially list conditions, if any, leading to initialize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence off Examiner or Attending Physician: The law requires that the death certificate be executed burial-translt Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 physicien Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 | Fetal death į in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? φ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy this certificate 2□ No 1 ☐ Yes 2XXNo 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) in by 4 - Homicide Hospitel TX Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) ş 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D52361 07-19-2006 662 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alan R. Segal MD 1500 Forest Glen Rd. Silver Spring MD 20910 31. Date filed (Month Pay Year) 2006 32. Registrar's Signature Societie State Registra

State of Maryland / Department of Health and Mental Hygiene - State Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 18, Year 8:10 PM Physician 2006 Joseph J. Jacoby /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/10/1925 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Days Months Hours 80 1**≤**M 2□F 399-18-3412 wI Director Usual Residence of Decedent the Maryland 10d, Inside City Limits 10c. City, Town or Location 10a State 10b. County itam 27 is marked other than "natural", or itams 23a or 28e-f ahow other treumatic avant, it is Medical Executer must be notified at 1 ☐ Yes 2 No MD Director Montgomery Poolesville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20837-United States 17630 Kohlhoss Rd. deeth Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Inhoprant: if Itam 27 is marked other than "natural; or Itan any injury or other treumatic avant, us Mudical Exemina Black, White, etc. 1 XYes 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify White þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Executive Administrative Asst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Jakubik Pauline Jakubie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Christiane M. Barrett/Daughter 17630 Kohlhoss Rd. Poolesville, MD 20837-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Jul 21 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2006 4 ☐ Donation 5 ☐ Other (Specify) MU0382 22. Name and Address of Facility
Rapp Funeral & Cremation Services Stole & Hohmann 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien end for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) t ☐ Yes 2 ☐ No. sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2(Z) No 1 Yes certificate 1 Yes to the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 Inpatient 2 Y ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day Year) 28b. Time of 28c 28d. Describe how injury occurred 27. Manger of Death Injury at Work? After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funerel Direct 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified ess of person who composition.

32. Registrar's Sheature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Dr. 31. Date filed (Month, Day, Year) State 1 2006 Registrar

|                            |  |                 | 1 - For<br>State<br>Registrar   | State of Maryla  |  |                            | nt of Hea<br>te of De                     |  |  | giene<br>Reg. No.             | 2006  | 22900   |
|----------------------------|--|-----------------|---|--|--|----------------------------|---|--|--|-------------------------------|---|---|
| ı                          | Physici<br>/Medic  |                 | <ol> <li>Decedent's Name (First, Middle, La<br/>Mary V. Jewell</li> </ol>   | st)  |  |                            |   |  | 2. Date of De<br>Month                 | ath Day                       | Year  | 3. Time of Death                              |
|                            | Examin<br>Funeral<br>Director  |                 | 214-30-9002   | HOCK CAMP  7. Age (In yrs  | US<br>s. last birthday)<br>72 Yrs.     | Ci                         | mbei                                      | Under 24 Hrs.                                | 8. Date of Bir<br>(Month, Da<br>Aug 24 | th                            | Col   | /   |
|                            | and w  |                 | Usual Residence of Decedent  10a. State 10b. County   | 10c. C   | ity. Town or Lo                        | ocation                    |   |  |  |                               |   | 10d. Inside City Limits                       |
|                            | Maryli<br>fed  | tor             | MD Allega   | nv   |  | and                        |   |  |  |                               |   | 1 ☐ Yes 2√ No                                 |
|                            | with the<br>a or 28a   | Director        | 10e. Street and Number 13521 McMullen H   | /  |  | 10f. Zi                    |   | 21502  |  | 10g. Citiz                    | en of What Cou  | untry?  |
| -0036                      | be filed within 72 hours after deeth with the Maryland stal tygliene ditylygiene deeth with the market ehow other then "natural", or terme 23a or 28a-f ehow event, the Marketal Examiner must be publified at   | ed by Funeral   | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's E   | 12. Was Decedent Ever in Armed Forces? 1   | 16a, Daca                              | 1 ☐ Yes                    | dent of Hispa<br>icify Cuban, №<br>2 No S | nic Origin? (S<br>Mexican, Puerl<br>Specify: | pecify Yes or No<br>o Rican, etc.)     |                               | 4. Race - Amer<br>Black, White                                | hite  |
| 21215                      | d within 72<br>jiene.<br>r then "ni  | Completed       | (Specify only highest graves   Elementary/Secondary (0-12)   unk   1  | College (1-4or 5+)   | (Give                                  | kind of wo<br>DO NOT i     | ork done durin<br>ise retired)            | ig most of wo                                | rking                                  |                               |   |   |
| Maryland 21215-0036        | should be filed wi<br>ind Menta! Hygien<br>marked other th<br>umatic event, the  | To Be C         | 17. Father's Name (First, Middle, Last, Carl Clark Yeas   |  |  |                            |   |  | ne <i>(First, Middle,</i><br>rginia M  |                               | Sumame)   |   |
| ary                        | 2 should be<br>and Menta<br>le marked<br>eumatic ev  |                 | 19a. Informant's Name/Relationship (  |  |  | •                          |   |  | iral Route Numb                        |                               |   |   |
| Baltimore, N               | permit. Pages 1 and 2 should by<br>Department of Heelih and Menia<br>Important: If Item 27 is marked<br>eny Injury or other treumatic e<br><u>pnce</u> .   |                 | Donald Jewell/spo  20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specific Control of | 20b.   | Place of Dispo<br>cemetery, cre        |                            |   | Hgwy C                                       | umber1a                                |                               | ID 2150<br>eation - City or 1                                 |   |
| Baltir                     | permit. P<br>Departme<br>Importan<br>eny Injur   |                 | 21. Signature of Funeral Service) icer  | Wade Directo   |  |                            |   | y Board<br>D 2120                            | 1 655 W.                               | Balt                          | timore :  | Street  |
|                            | Physician / Medical Examiner but site pe executed site private its | edical Examiner | 23a. Part Lenter the disease, or com shock, theart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b. Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.) | oquence ot):                           |                            |   |  |  |                               | , or  | Approximate Interval Between Onset and Death  |
| P.O. Box 68                | death certif<br>e ettending<br>id for use a  | Physician/Med   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown   | 23c. If yes, outcome of preg<br>1 Live birth 2 Fe<br>4 Pregnant at time of<br>9 Unknown                    | tal death 3[                           | ⊒Ectopic p<br>⊒ Other (s   |   |  |  | 23                            | 3d. Date of delin   | ∕ery<br>Day Year                              |
|                            | uires that<br>signed by  | þ               | Part II. Other significant conditions of WINELY METHSTA   | •  | •                                      | , ,                        | cause given in                            | Part I.                                      |  |                               |   | the cause of death?                           |
| Division of Vital Records, | hysicien: The law requires that the<br>his certificate hes been signed by th<br>i director, page 2 should be detach  | Completed       |   |  |  |                            |   |  |  |                               | 24b. Were aut<br>prior to o<br>death?<br>1 \( \sum \text{Yes} | opsy findings available ompletion of cause of |
| Vita                       | icien:<br>certific<br>rector,  | Be              | 25. Was case reterred to medical examiner?  | Hospital:  |  |                            | 0.1                                       |  | ath (Check only o                      |                               |   |   |
| 1 01                       | ding Phys<br>h.<br>After this<br>funeral di  | n: To           | 1 Yes 2 KNo 27. Manner of Death   | 28a. Date of Injury (Month, Day Year)  | ER/Outpaties<br>28b. Time of<br>Injury |                            | 28c. Injury at<br>Work?                   | 4 ☐ Nursing F                                | lome 5 Resi                            |                               |   | ify)  |
| ivisior                    | or Attending Physicien:<br>iffer death.<br>Director: After this certifics<br>in by the funeral director, is  | ertification;   | 1 Natural 5 Pending investigatio 3 Suicide 6 Could not b determined   | 1  | home, tarm, st                         | М                          | 1 🗆 Yes                                   | 2 🗆 No                                       | 28t. Location (.<br>City or To         | _<br>Street and<br>wn, State) | Number or Ru  | ral Route Number,                             |
| _                          | To the Hospitel or Atlandi<br>within 24 hours after death.<br>To the Funerel Director: A<br>completely filled in by the fu   | Medical Ce      | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medical Example  | sysician: To the best of my kr<br>niner: On the basis of examinand manner stated.                          | nowledge, deat<br>nation and/or in     | h occurred<br>evestigation | at the time, on, in my opinion            | date and place<br>on, death occu             | , and due to the<br>irred at the time, | cause(s) a<br>date and p      | and manner as<br>place, and due                               | stated.<br>to the cause(s)                    |
| )                          | To th<br>Within<br>To th<br>Compl  | Me              | 29b. Signature and title of continue  | - mò   |  |                            | c. License nu                             |  | r. i mo)                               |                               | signed (Month   |   |
|                            |  |                 | 30. Name and address of person who JAMET R. MOET  | v. m.p. 1068   | NATIO                                  | Print)                     | H164W                                     | At L.  | AVALE,                                 | MAR                           | como  | 21502   |
|                            | Sta<br>Registi   |                 | 31. Date tiled (Month, Day, Year)   | 34 Registrar's Sign  | nature Sh                              | well.                      |   |  |  |                               |   |   |

|             |  |                | For<br>State<br>Registrar   | State of Ma  |                                    | oartment<br>e <i>rtificate</i>                  |                      |                                  |  | Reg. No.                           | 06 2290   |            |
|-------------|--|----------------|---|--|------------------------------------|---|----------------------|----------------------------------|--|------------------------------------|---|------------|
|             | Dhysiai  |                | 1. Decedent's Name (First, Middle, Last)  |  |                                    |   |                      |                                  | 2. Date of Dea                           | Day 6.0                            | 3. Time of Death  |            |
|             | Physici<br>/Medic  | al -           | Goldie V. Jackson   |  |                                    |   |                      |                                  | July                                     | 12,20                              | 000   | М          |
| 1           | Examin   | er             | 4a. Facility Name (If not institution, give s   | treet and number)  | nital                              | 4b. City, 1                                     | fown, or Loc         | cation of Dea                    | " Li                                     | 4c. County                         | or Death  |            |
|             |  |                | 5. Social Sectifity Number 6. Sex   | erue No:   | (In yrs. last birthda              | Under   | Year If              | Under 24 Hr                      | S. 8. Date of Birt                       | h                                  | 9. Birthplace (State or Forei                               | ion        |
|             | Funeral Director   |                |   | M 2∏F  | 61 Yrs.                            | Months  |                      | lours Mir                        |  | y, Year)                           | Country) Maryland   | 9          |
|             |  |                | Usual Residence of Decedent   |  | 01                                 |   |                      |                                  | red 9,                                   | 1747                               | rial y land   |            |
|             | yland<br>10w   |                | 10a. State 10b. County  |  | 10c. City, Town or                 | Location  |                      |                                  |  |                                    | 10d. Inside City Limi                                       |            |
|             | Man  | to             | MD  |  | Baltimo                            | ce  |                      |                                  |  |                                    | 1√ Yes 2□N  | 40         |
|             | r 28   | Director       | 10e. Street and Number  |  |                                    | 10f. Zip  |                      |                                  |  | 10g. Citizen of V                  | Vhat Country?   |            |
|             | th wit   | la<br>D        | 5009 Frankford Ave  | nue  |                                    |   | 2120                 | 6                                |  | USA                                |   |            |
|             | dea  | Funeral        | 11. Marital Status  | 2. Was Decedent E-<br>Armed Forces?  | ver in U.S.                        | B. Was Deced                                    | ent of Hispa         | anic Origin? (<br>Mexican, Pue   | Specify Yes or No<br>rto Rican, etc.)    | - 14. Raci<br>Blac                 | e - American Indian,<br>k, White, etc.                      |            |
| 9           | or It  | Y Fu           | 1 Never Married 2 Married   | 1 ☐ Yes 2 🔯 No<br>If Yes, Give<br>Year or Dates:                               |                                    | 1 ☐ Yes 2                                       |                      | Specify:                         |  |                                    | black   |            |
| 21215-0036  | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "neturel", or lleme 23a or 28e-f ehow<br>with the Modical Examinar must be notified at  | d by           | 3 Widowed 4 Divorced  |  | 100 Day                            |   |                      |                                  |  |                                    | isiness/Industry  |            |
| Γγ          | n 72 n   | Completed      | 15. Decedent's Educ<br>(Specify only highest grade  | completed)   | (Gi                                | cedent's Usua<br>ve kind of wor<br>i. DO NOT us | k done durir         | ing most of w                    | orking                                   | 160. Kind of Bu                    | isiness/muustry   |            |
| 12          | withir<br>than   | ğ              | Elementary/Secondary (0-12)   | College (1-4or 5+  | -)                                 | sing a  |                      |                                  |  | private                            | homes   |            |
| <b>d</b> 2  | Hygid<br>Hygid<br>Ther   | ပိ             | 17. Father's Name (First, Middle, Last)   |  |                                    |   | 18.                  | . Mother's Na                    | ame (First, Middle,                      | Maiden Sumam                       | re)   |            |
| an          | Mental Merked o  | To B           | Thomas Bright   |  |                                    |   |                      | Edi                              | th Mosle                                 | У                                  |   |            |
| Maryland    | SEE  | -              | 19a. Informant's Name/Relationship (Ty)   | oe, Print)   | 19b. Ma                            | iling Address                                   | (Street and          | Number or F                      | Rural Route Numbe                        | er, City or Town,                  | State, Zip Code)  |            |
| ž           | 22 4 2 5 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5   |                | Pamela Brickell/da  | ughter   | 3415                               | Gwynn   | s Fall               | ls Pkw                           | y #A4 Ba.                                | ltimore,                           | MD 21216  |            |
| e,          | of Her   |                | 20a. Method of Disposition  |  | 20b. Place of Dis                  | position (Name                                  | ne of<br>ther place) | İ                                | Date                                     | 20c. Location -                    | City or Town, State   |            |
| ZE          | Page<br>nent<br>nt: If<br>iry or   |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐ R<br>4 ☑ Donation 5 ☐ Other (Specify)  | emoval from State  |                                    | -   |                      | 1                                |  |                                    |   |            |
| Baltimore,  | permit. Pages 1 and<br>Department of Heelt<br>Important: If Item 2'<br>any Injury or other<br>once.  |                | 21. Signature of Funeral Service License RONALO   | ades Dire  | ctor                               | State and                                       | Addres A             | i yacibban                       | d 655 W.                                 | Baltim                             | ore Street  |            |
| Ω           | 88 = 8   |                | Jums/1  | 1/1/100  |                                    | Baltimo   | ore, M               | TD 212                           | 201                                      |                                    |   |            |
| 8760,       | The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law required to the election of the election of the principal of the law required to the | al Examiner    | shick, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a  | consequence of):                   | a<br>f H  | he                   | Colo                             | n  |                                    | Onset and Death   |            |
| 9           | tificate<br>ig phys<br>as the  | ledical        |   |  |                                    |   |                      |                                  |  |                                    |   |            |
| P.O. Box    | it the death certifica<br>by the ettending ph<br>tached for use as th  | Physician/M    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 3c. If yes, outcome of<br>1 □ Live birth 2<br>4 □ Pregnant at t<br>9 □ Unknown | Fetal death                        | 3 □Ectopic pro<br>5 □ Other (spe                |                      |                                  |  | 23d. Dat<br>Mo                     | e of delivery<br>nth Day Year                               |            |
| Records, P. | uires that the signed by ald be detacted   | ρ              | Part II. Other significant conditions cor   | tributing to death bu  | t not resulting in the             | underlying ca                                   | ause given ii        | in Part I.                       | 1  | obacco use conti<br>Yes 2 □ No     | ribute to the cause of death?<br>3 ☐ Probably 4 ☐ Unknow    |            |
| Ö           | s been si<br>should  | Completed      |   |  |                                    |   |                      |                                  | 24a. Was                                 | an 24b. \                          | Were autopsy findings availat                               | ble        |
| Re          | The lav  | E              |   |  |                                    |   |                      |                                  | autor<br>perfo                           | rmed?                              | prior to completion of cause of<br>leath?<br>I □ Yes 2 □ No | <i>)</i> 1 |
| Vital       | sician: Th<br>certificate<br>irector, pag  | Bec            | 25. Was case referred to medical  | 3.   |                                    |   | 26                   | 6. Place of D                    | eath (Check only o                       |                                    |   |            |
| >           |  | 2              | examiner? 1 Yes 2 16  | ospital: 1 Limpatier   | nt 2 ER/Outpat                     | ient 3 DO                                       | Other:               | 4 Nursing                        | Home 5 Resid                             | dence 6 Oth                        | er (Specify)  |            |
| u of        |  |                | 27. Manner of Death 1 ☐ Matural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day   | Year) 28b. Time                    | of 2  | 8c. Injury at Work?  |                                  | 28d. Describe                            | how injury occurr                  | red   |            |
| <u>0</u>    | Attending<br>r deeth.<br>ector: Afte<br>by the fune  | catle          | 2 Accident investigation  |  |                                    | М   |                      | 5 2 □ No                         |  |                                    |   |            |
| Division    | or Att<br>after de<br>Direct<br>in by t  | Certification: | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Inju<br>building, etc.   | ry - At home, farm,<br>. (Specify) | street, factory                                 | , office             |                                  | 28f. Location (                          | Street and Numb<br>vn, State)      | er or Rural Route Number,                                   |            |
|             | To the Hospital or Attend within 24 hours efter death To the Funeral Director: completely filled in by the   | Medical Ce     | 29a. Certifier 1 Certifying Physical Examination  | sician: To the best of<br>ner: On the basis of<br>and manner stat              | examination and/or                 | eath occurred investigation,                    | at the time, o       | date and place<br>ion, death occ | e, and due to the<br>curred at the time, | cause(s) and ma<br>date and place, | nner as stated.<br>and due to the cause(s)                  |            |
|             | To the within 2 To the comple  | Me             | 29b. Signature and title of certifier   |  |                                    | 290   | . License nu         | umber                            |  | 29d. Date signer                   | d (Month, Day, Year)  |            |
|             | ⊢s⊢ŏ   |                | 100   | \  |                                    |   | 895                  | 136                              |  | 9112                               | 106   |            |
|             |  |                | 30. Name and address of person who co   | orpleted cause of de   | path (Item 23a) (Typ               | pe, Print)                                      | lani                 | d Gn                             | meral                                    | Hos                                | pital   |            |
|             | Sta<br>Regist  | ate<br>rar     | 31. Date filed (Month, Day, Year)  JUL 2 1 2006   | 12. Registra   | r's Signature                      | alle s  |                      |                                  |  |                                    |   |            |

|          |  |                 | For<br>State<br>Registrar   | State  | of Marylan   | •                      | artment of rtificate of               |                           |                   |                                 | giene<br>Reg. No.       | 006  | 22902   |
|----------|--|-----------------|---|--|--|------------------------|---------------------------------------|---------------------------|-------------------|---------------------------------|-------------------------|--|---|
| -        | Physicia   | 20              | 1. Decedent's Name (First, Middle   |  |  |                        |                                       |                           |                   | 2. Date of Dea                  | Day                     | Year   | 3. Time of Death                              |
|          | /Medic   | _               | Kenneth Louis   |  |  |                        |                                       |                           |                   | July                            | 20,                     | 2006   | 8:25 P M                                      |
|          | Examin   | er              | 4a. Facility Name (If not institution   | -  | ımber)   |                        | 4b. City, Town,                       | or Location :<br>timore   |                   |                                 |                         | ounty of Death<br>Baltim                             |   |
|          | Funeral  |                 | 4145 India Ave  | 6. Sex   | 7. Age (In yrs.  | last birthday)         | If Under 1 Year                       | r If Under                | 24 Hrs.           | 8. Date of Birt                 | h                       | 9. Birth   | place (State or Foreign                       |
|          | Funeral<br>Director  |                 | 216-14-4363   | 1(M 2□ F   | 81   | Yrs.                   | Months Days                           | Hours                     | Min.              | Oct. 3,                         | 1924                    | Mari   | yland   |
|          | D >  |                 | Usual Residence of Decedent  10a. State 10b. County   |  | 10c Cit  | ty, Town or Lo         | postion                               |                           |                   |                                 |                         |  | 10d. Inside City Limits                       |
|          | ehov   | 5               |   | t imaka  | 100.010  |                        | iltimore                              |                           |                   |                                 |                         |  | 1 □ Yes 2 No                                  |
|          | the A  | rect            | Maryland Bala  10e. Street and Number   | timore   |  | 50                     | 10f. Zip Code                         |                           |                   |                                 | 10g. Citizer            | n of What Cou  | ntry?   |
|          | 3a or  | Funeral Directo | 4145 India Aver   | ше   |  |                        |                                       | 21                        | 236               |                                 |                         | u.s.A  | •   |
|          | death  | ner             | 11. Marital Status  | 12. Was Dec<br>Armed F                             | edent Ever in U  | .S. 13.                | Was Decedent of<br>If Yes, specify Cu | Hispanic Or               | igin? (Spe        | city Yes or No-                 | - 14.                   | Race - Ameri<br>Bleck, White,                        |   |
| 0        | or the   | by Fu           | 1 Never Married 2 Marr  | ied 1 X Yes<br>If Yes, G<br>Year or I              | 2 □ No   |                        | 1 □ Yes 2 💢 No                        |                           |                   |                                 |                         | pecity: Wh   |   |
| Ś        | ture   |                 | 3 Widowed 4 Divorced  |  | Dates:   | 16a, Dece              | dent's Usual Occu                     | pation                    |                   |                                 | 16b. Kind               | of Business/Ir                                       | ndustry                                       |
| Ċ        | n na   | Completed       | (Specify only highes<br>Elementary/Secondary (0-12)   | st grade completed                                 | (1-4or 5+)   | (Give                  | kind of work done DO NOT use retir    | e during mos<br>ed)       | t of worki        | ng                              |                         | l Unio   | •   |
| 7        | glene<br>glene<br>er the   | Mo              | 8   | Coulege  | 1-401 547  | Oper                   | iating E                              | -                         |                   |                                 |                         | ruction  | n   |
|          | be filed within 72 hours after death with the Marylan Hydjene. d other then "naturel", or iteme 23a or 28a-f show event, the Mydical Exam or must be notified at   | Be              | 17. Father's Name (First, Middle,  John Peter   |  |  |                        |                                       |                           | er's Name<br>heri | (First, Middle,                 |                         |  |   |
| 2        | should be filed within 72 hours after death with the Maryland and Mental Hygiene. I Hygiene. I Hygiene in marked other then "naturel", or items 23a or 28a-f show umatic event, it a Medical Examinar must be notified at  | 2               | 19a, Informant's Name/Relations   |  |  | 10h Mailie             | ng Address (Stree                     |                           |                   |                                 | rempe                   |  | a Codel                                       |
| ~        |  |                 | Gary J. Kahl  | (son)  |  |                        | Chapmai                               |                           |                   |                                 |                         |  | 0 0000)                                       |
| 2        | f Hea  |                 | 20a. Method of Disposition  |  | 20b. F   |                        | sition (Name of<br>matory or other pl |                           | <u> </u>          | Date                            |                         | tion - City or T                                     | own, State                                    |
| Ē        | Pages<br>nent of I<br>ant: If It<br>ury or o   |                 | 1 Burial 2 □ Cremation<br>4 □ Donation 5 □ Other (S   |  | State  |                        | Cemeter                               |                           | 7/22              | /2006                           | Park                    | ville,   | Maryland                                      |
| Daltimo  | permit. Pages 1 end 2<br>Department of Health a<br>Important: If Item 27 is<br>any Injury or other tre   |                 | 21. Signature of Funeral Service  |  |  | 22                     | 2. Name and Add                       | ress of Facili            | y Sch             | imunek                          | Funer                   | al Home<br>21236                                     |   |
|          |  |                 | 23a. Part1. Enter the disease, or shock, or heart failure. List   | complications that                                 | caused the deat  |                        |                                       |                           |                   |                                 |                         | 21230  | Approximate<br>Interval Between               |
|          | Physician of Medical  (Medical  i Examiner   | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | 6 c  | (or as a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence or a consequence of or a consequence or a consequence of or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequenc |                        | cer                                   |                           |                   |                                 |                         |  | Onset and Death                               |
|          | The law requires that the death certifical site has been signed by the attending phypage 2 should be detached for use as the   | Physician/Medi  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 1 Live   | utcome of pregna<br>birth 2 Peta<br>nant at time of d  | I death 3              | Ectopic pregnan                       | су                        |                   |                                 | 230                     | I. Date of deliv<br>Month                            | ery<br>Day Year                               |
| cords, r | quires the   | ۾               | Part II. Other significant condition  |  | death but not res  |                        | nderlying cause g                     | iven in Part I            | i.<br>            |                                 | obacco use<br>res 2 🗆 t | 1  | he cause of death?                            |
| Leco     | he law red<br>e hes bee<br>age 2 shor  | Completed       |   |  |  |                        | . ,                                   |                           |                   |                                 | med?                    | 4b. Were auto<br>prior to co<br>death?<br>1 \sum Yes | opsy findings available ompletion of cause of |
|          | rtifice  | 0               | 25. Was case referred to medical  |  |  |                        |                                       | 26. Place                 | e of Death        | 1 ☐ Yes                         | ne)                     | 1 103  | 20 100  |
| ><br>5   | Physicien:<br>r this certifior<br>ral director,  | To B            | examiner?   |  |  | ER/Outpatier           | 11 30 DOV                             |                           | ursing Hor        | ne 5Ă Resid                     | dence 6                 | Other (Special                                       | fy)   |
|          | Attending Pir death.   | atlon:          | 27. Manner of Death  1 Natural 5 Pendin 2 Accident Investig   | gation   | of Injury<br>oth, Day Year)  | 28b. Time of<br>Injury | W                                     | uryat<br>ork?<br>∐Yes 2 □ |                   | 28d. Describe h                 | now injury o            | ccurred  |   |
| DIVIS    | To the Hospital or Attending Physicien: The i<br>within 24 hours after death. To the Funeral Director: After this certificate he<br>complately filled in by the funeral director, page   | Certification   | 3 Suicide 6 Could determ  | 288. Plac  | e of Injury - At hi<br>ding, etc. (Specif  | ome, farm, str<br>fy)  | eet, factory, office                  | )                         | 1                 | 28f. Location (5<br>City or Ton |                         | lumber or Run  | al Route Number,                              |
|          | # Hospit<br>24 hour<br>Funer<br>ately fills  | edical (        |   | ng Physician: To the<br>Examiner: On the<br>and ma | basis of examina   | ation and/or in        | vestigation, in my                    | opinion, dea              | ath occurre       | ed at the time,                 | date and pla            | ace, and due t                                       | o the cause(s)                                |
|          | To th<br>To th<br>compl  | Me              | 29b. Signature and title of certifie  | 1/1  | 1,)  |                        | 29c. Licer                            | se number                 |                   |                                 | 29d. Date s             | igned (Month,  | Day, Year)  ( )1) 2/237                       |
|          |  |                 | Win Cl  | Valeful  | d MV   | 2                      | 03                                    | 243.                      | 56                |                                 | 7-3                     | 21-0   | <u>C</u>                                      |
| ()       | 1/   |                 | 30. Name and address of person  | who completed cau                                  | se of death (Iter  | n 23a) (Type.          | Print)                                |                           | D                 | 01 3 =                          | . 2                     | 11 10  | 20 2020                                       |
|          |  | † a             | 31. Date filed (Month, Day, Year)   | Watert   | registrar's Signa  | ature.                 | IWNICII                               | 7 -3                      | UI.               | X.LLCC                          | 1)9                     | 170.10   | 11) 2101/                                     |
| 4.       | Sta<br>Registr   |                 | JUL 2 1   | 2006   | Siew.  | D. A                   | rave                                  |                           |                   |                                 |                         |  |   |

|  | 1                      | For State   | State of Maryland /  |                                   | ent of Health  |                                 |                                 |                                 | 06                                   | 22903  |
|--|------------------------|---|--|-----------------------------------|--|---------------------------------|---------------------------------|---------------------------------|--------------------------------------|--|
| ysicia   |                        | 1. Oocodunt's Name (Fuel Middle, Last)  | I KEYSEY   |                                   |  |                                 | 2. Date of Death<br>Month       | Dev                             | Year<br>2006                         | 3. Time or Dearn                                 |
| Medic<br>kamira  | -                      | 4s. Facility Name (If not Institution, give   |  |                                   | Chy, Yown, or Lucation                                       |                                 | w                               | 4c. County                      |                                      |  |
| neral<br>ector   |                        | 5. Social Security Number   6. Se   | The second secon | Yra. Mon                          | ter t'Year   Il Und  | er 24 Hrs.                      | 8. Dais of Birn<br>March &      | 21940                           |                                      | GINIQ.   |
|  |                        | Usual Residence of Decadent 10a. State 10b. County  | 100. Çily, Yo  | own or Location                   |  |                                 |                                 |                                 | . 10                                 | od, Inzide City Limits                           |
| netibas  | Director               | Maryland N/A  | · B  |                                   | 10re   |                                 | 10                              | g. Cirizen of 1                 | What Count                           | 1 000 S U NO                                     |
| Color must be needed at  | Funeral D              | 4140 Marib  | 12. Was Decedent Ever in U.S.<br>Armed Forces?   | 13. Wgs 0                         | 2/22<br>ecadent of Hispanic<br>specify Cuban, Mexi           | Origin? (Spe                    | city Yes or No-                 |                                 | S.A.<br>re · America<br>ck. White, e |  |
| Executor   | 3                      | 1 Never Married 2 Married 3 X Widowed 4 Diverced  | I O Yes 25 No<br>II Yes, Give<br>Year of Daties:   | 1                                 | as 25 No Spec  |                                 |                                 | Specif                          | Blo                                  | ick  |
| Medical a  | Completed              | IS. Ducodura's Ed<br>(Specify only nigness grad<br>Eissnessayy/Secondary (0-12)                             | de completed) : 11 College (1-4ot 5+) :  | ide. IDO N                        | Usual Occupation<br>of work done during a<br>OT use relified | mosi of worki                   | ng I                            | db. Kind of B                   |                                      | r •  |
| event I  | 8                      | 17. Father's Name (First, Middle, Last)   |  | 1101                              | nema   | lother's Name                   | (First, Middle, A               |                                 | mes                                  |  |
| neer of the charme<br>alber traumeric  | 0                      | 19a, Informant's Name Relationship (1   | you. Print (grand son)   | 19b. Mailing Ad                   | drace (Stront and No   | imbur or Aura                   | A House Number,                 | City or Town                    | State. Zip                           | Codej.   |
| = 5  |                        | 20a. Method of Disposition  1 Method 2 Ocemetion 3 O  | Flamoval from State  | of Disposition                    | (Name of y or other place)                                   | 7/50                            | Datu.                           | OG. Location                    | D. IVIC<br>- City or To              | wn, State  |
| Any Infusy Ages  |                        | 21. Signature of Furnerus Service Intern  |  | T. Call<br>22. Nar<br>1 Jose      | no and Address of F  |                                 | Funera                          | zien<br>21 Hoi                  | Buc<br>me l                          | nie Ma   |
| 9  | -                      | 23x. Party Error the disclass, or com-<br>should or heart failure. List only                                | plication that caused the death. Cone cause on each line.  | Do not enter the                  | 2_WiNor<br>mode of dying, such                               | n as cardias                    | or ruspiratory are              | المناب                          | Y\a                                  | Approximate Interval Botween Onset and Douth     |
| icián<br>dicai<br>niner  | ٠                      | Immedial/ Cause (Final disease or condition resulting in death)   | Due to for as a consequen  |                                   | e Colq   | iova                            | is fuller                       | 4 121                           | ose.                                 | unknow.  |
|  | alher                  | Sequentially list conditions, if any, teacing to immediate cause. Enter Understand Cause (Oisease or injury | Due to (or as a consequent   | ncus of):                         |  | ·                               |                                 |                                 |                                      |  |
| ing paysonin and<br>e as the burizh-usnsk  | al Examin              | that initiated events<br>resulting in death) Last   | Due to (or as a consequen  | rce oi):                          |  |                                 |                                 |                                 |                                      |  |
|  | Medical                | IF FEMALE:  | 23c. If yes, outcome of pregnancy  | v                                 |  |                                 |                                 | 224 5                           | are at defini                        |  |
| diestor .  | Physician              | 23b. Was decedent pregnant in the past 12 months? 1 0 Yes 2.2 No. 9 1 Unknown                               | 1 Drive birth 2 DFotsl de<br>4 Pragnant at liese of doub<br>3 Unknown  | eath 3 Ect                        | pie pregnancy<br>er (specify)                                |                                 | · · · · · ·                     |                                 | ate of delivi                        | Day Year   |
| signed to<br>iid be dete   | 6                      | Part II. Other significant conditions of  | contributing to death but not resulti-   | ng in the under                   | lying cause given in F                                       | Part I.                         |                                 | 00000 UNU CO                    | ntribule le i<br>3 ☐ Prot            | he cause of desin? .                             |
| ge Z ahos  | Campleted              |   |  |                                   |  |                                 | 24s. Was a autopi               | n 24b                           | Were auto<br>prior to co<br>death?   | poey findings available<br>impletion of cause of |
| de joi   | Be Co                  | 25. Was case reletted to medical  |  |                                   | 26.1   | Place of Dear                   | 1 Ves                           |                                 | 1 🗆 Yes                              | 20 No  |
| Pre G  | 10                     | 1 Ves 30040   |  |                                   | Other: 4   |                                 | ome 5 Neeld                     |                                 | thur (Speci                          | N)   |
| Aller  | lon                    | 27. Memar of Dualts 1 Prending  | (Month, Quy Year)  | 8b. Time of<br>Injury             | 28c. Injury at Wark?   | 100                             | 25d, Describe h                 | aw injury ood                   | urred                                |  |
| is ing Funare: Drector: Atler this Gentussee has beind signed by the elemanopopistics of compilerly filled in by the funarel disector, page 2 attound be defected for us | Medical Certification: | 2 Nocident investigation 3 Suicide 5 Could not to 4 Homicide determined                                     | 9 00 00 00   |                                   |  | - LINO                          | 28r. Location (S<br>City or You | trout and Num<br>n, Stare)      | noer or Run                          | al Roule Number,                                 |
| to Fundre  | dicalC                 | 29a. Conflict (Check way 2 Medical Exa  | hysician: To the best of my knowle<br>miner: On the basis of examination<br>and manner stated.   | edge, death oo<br>n and/or invosi | gation, in my opinion  | the und place<br>is death occur | and due to the o                | ause(s) and s<br>late and place | manner as :<br>e, and due :          | sialed.<br>0 tha causo(s)                        |
| S 40   | Z                      | 29b. Signature and title of countries.  |  |                                   | 29c. License nun   | nber .                          |                                 | Dd. Date sign                   | ned (Manth,                          | Ouy. Year)                                       |
|  |                        | 1   | Heading Phys   | rago                              | 7518   | 53                              |                                 | ナント                             | 18                                   | 2006   |
| 3  |                        | 30. Nume and Source of person who   | 1  |                                   |  | Fla ace 14                      | er Stre                         | + L.                            | 17                                   | ta 2.177.6                                       |
| Segis  | ate<br>trar            |   | 32. Pagişirar's Signatur   |                                   | <u>. مد</u>  | LOVEN                           | 1(0)                            | ,                               | · / · INN                            | 7 -100.  |

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2<u>006</u> Month **Physician**  $P^{M}$ 13, Ju<sub>1</sub>y 4:30 .T. B. Kimp /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mariner Health of Glen Burnie Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1⊠M 2□F Months Director 1938 261-58-3111 67 Mississippi Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b County al Hygiene. other then "naturel", or iteme 23a or 28e-f ehow went. the Madical Examinal must be notilled at 1KTYes 2 □ No Director Anne Arundel Glen Burnie MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21060 USA 7355 Furnace Branch Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours atter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Budd Company Heavy Equipment Operator 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be find Mental I ie marked M. C. Johnson J. B. Kimp ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) , 1 and 2 st of Health ar i item 27 ir or other tr 4634 Morning Glory Trail, Bowie, MD Bonita Farrall/Daughter 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Deps riment of H
Important: If ite
any injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial Park 7/19/06 Habart, IN 4 ☐ Dopation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Guy & Allen Funeral Directors 2959 W 11th Avenue, Gary, Indiana 46404 remus 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode disping, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 14 attending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) ete hes been signed by the a pege 2 should be detached to P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ል Records. 1 ☐ Yes 2 ₺ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificete 1 Yes bete 2 No 1 of Vital Atter this certition tuneral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **N**o 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; Division 5 Pending Injury 1 Natural within 24 hours atter death.

To the Funeral Director: Attended in by the turn 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide atter Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ‡ 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 enningto 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 2 1 2006 Registrar

| Physician<br>/Medica<br>Examine<br>Funeral<br>Director   | in<br>al       | Decedent's Name (First, Middle, Last Su Hyon Kang   | )                     |  |   |                                     |                             |  |                    |   |              |                       |                           |  |
|--|----------------|---|-----------------------|--|---|-------------------------------------|-----------------------------|--|--------------------|---|--------------|-----------------------|---------------------------|--|
| Funeral Director   |                |   |                       |  |   |                                     |                             |  |                    | 2. Date of De<br>Month<br>07/15/20      | Da           | у                     | Year                      | 3. Time of Dear                                    |
| Director   | -              | 4a. Facility Name (If not institution, give<br>Randolph Hills Nur   |                       | ,  |   | Whea                                | aton                        | Location of                            | f Death            |   | 40           | County                |                           |  |
| 0  |                | 5. Social Security Number 6. Se 213-94-5523   | х<br>Пм <b>3</b> ДП F | 7. Age (In yrs. 92                                   | iast birthday)<br>Yrs.                    | If Under<br>Months                  |                             | If Under 2<br>Hours                    | Min.               | 8. Date of Bir<br>(Month, Da<br>06/24/1 |              | )                     | 9. Birtho<br>Cour<br>Kore | place (State or For<br>htry)                       |
| e-f show   |                | 10a. State 10b. County MD Montgomer   | <i>c</i> y            |  | ity, Town or Lo                           | ocation                             |                             |  |                    |   |              |                       | 1                         | 0d. Inside City Lin                                |
| h with th  | Dire           | 10e. Street and Number 15413 Maple Ridge  | Road                  |  |   | 10f. Zip                            |                             |  |                    |   | 10g. Ci      | tizen of W            | hat Cour                  | ,  |
| urs a  | by Fur         | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced   |                       | 2 XNo<br>∕e  |   |                                     | dent of Hi<br>cify Cuba     | spanic Orig<br>n, Mexican,<br>Specify: | in? (Spe<br>Puerto | ecify Yes or No<br>Rican, etc.)         | )-           |                       | - Americ<br>k, White,     | an Indian,<br>etc.                                 |
| within 72 h<br>iene.<br>than "natu   | Completed      | 15. Decedent's Edu<br>(Specify only highest grad<br>Elementary/Secondary (0-12)   |                       | 1-4or 5+)  | 16a. Dece<br>(Give<br>life.               | kind of wo<br>DO NOT us             | rk done a                   | uring most                             | of worki           | ng                                      |              | and of Bu             |                           | dustry   |
| 2 should be filed within and Mental Hygiene. Is marked other than sumatic event, ILAM  | To Be C        | 17. Father's Name (First, Middle, Last) Unknown   |                       |  |   |                                     |                             |  | 's Name            | o (First, Middle,                       |              |                       |                           |  |
|  |                | 19a. Informant's Name/Relationship (Ty Yong Chol Kim /  20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F  | Grands                | State 20b.   | 15413<br>Place of Dispo<br>cemetery, crer | Mapl<br>sition (Nari<br>matory or o | Le Ri                       | dge F                                  | Road               | ni Route Number, Woodb<br>Date<br>/2006 | ine,         | MD                    | 2179<br>City or To        | 7<br>wn, State                                     |
| permit. Pege<br>Depertment o<br>Important: If<br>any injury or<br>once.  | Ī              | 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens   |                       | Meac   | Gan                                       | Name an                             | d Addres                    | s of Facility  Funer                   | al H               | 1                                       | eadaw        | ridae                 |                           | rial Park,   |
| ysicia<br>ne bur   | dical Examiner | 23a. Part1. Enter the disease, or compleshock, or heart failure. List only a Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last | Due to (              | arachnoic  | Hemorra<br>quence of):<br>quence of):     |                                     | e of dying                  | j, such as c                           | ardiac d           | r respiratory a                         | rrest,       |                       |                           | Approximate Interval Between Onset and Death Years |
| at the death certifical by the attending prinached for use as the  | Me             | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown   | 1☐Live b              | come of pregni<br>irth 2 Feta<br>ant at time of cown | al death 3                                | ]Ectopic pr<br>] Other (sp          |                             |  |                    |   |              | 23d. Date<br>Mon      |                           | ry<br>Day Year                                     |
| w requires that been signed be should be determined by the bear by | 2              | Part II. Other significant conditions cor   | ntributing to de      | eath but not res                                     | sulting in the u                          | nderlying c                         | ause give                   | n in Part I.                           |                    |   |              |                       |                           | e cause of death?<br>ably 4 □Unkno                 |
|  | Completed      |   |                       |  |   |                                     |                             |  | <del></del>        | 24a. Was<br>autor<br>perfo<br>1 🗆 Yes   | osy<br>rmed? | di<br>di              | rior to cor<br>eath?      | osy findings availanpletion of cause               |
| iyalci<br>iis ceri<br>direct   | To Be          | 25. Was case referred to medical examiner?  1 ☐ Yes 2X No   | Hospital: 1 □ I       | npatient 2   | ] ER/Outpatien                            | t 3□ DO                             | A Othe                      |  |                    | Check only o                            |              | 6 □Othe               | r (Specify                | ·)   |
| Attending Ph r death. ector: After th by the funeral   |                | 27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be  | 28a. Date (<br>(Mont  | of Injury<br>th, Day Year)                           | 28b. Time of<br>Injury                    | M 2                                 | 8c. Injury<br>Work<br>1 🗆 Y |  | 0                  | 28d. Describe h                         | now inju     | ry occurre            | od                        |  |
|  |                | 4 Homicide determined   | buildir               | of Injury - At h                                     | fy)                                       |                                     |                             |  |                    | City or Tov                             | vn, State    | 9)                    |                           | Route Number,                                      |
| in 24 hc<br>lin 24 hc<br>lhe Fun<br>ipletely i   | edica          | 29a. Certifier Certifying Physical Canada Control (Check only one)  | ner: On the ba        | asis of examina                                      | ation and/or inv                          | estigation,                         | at the time<br>in my op     | e, date and<br>inion, death            | place, a           | and due to the                          | date and     | and mar<br>d place, a | ner as st<br>nd due to    | ated.<br>the cause(s)                              |
| To the within 2 To the complet   | ¥              | 29b. Signature and title of certifier   | Cu                    | ~  | フ   |                                     | . License<br>0210           |  |                    |   |              | te signed             |                           | Day, Year)   |

|   |  |                     | State of Maryland / Depa<br>State of Maryland / Depa<br>State of Maryland / Depa<br>State of Maryland / Depa<br>State of Maryland / Depa<br>Registrar  | rtment of Heal   |  |  |                                      |  |
|---|--|---------------------|--|--|--|--|--------------------------------------|--|
|   | Physicia<br>/Medic   |                     | 1. Decedent's Name (First, Middle, Last)  Vincent C. Kimball, Jr.  |  | 3  | Date of Death<br>Month                       | _                                    | 3. Time of Death 1730M   |
|   | Examin   | er                  | 4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center   | 4b. City, Town, or Loca<br>Fallston  |  |  | Harfor                               |  |
|   | Funeral<br>Director  |                     | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 2 F 48 Yrs.  |  | Juder 24 Hrs. 8. Durs Min. Se                          | Date of Birth<br>(Month, Day,<br>ept 27,     | <sup>Year)</sup> 957                 | Birthplace (State or Foreign Country) Maryland                   |
|   | Maryland<br>-1 ehow  |                     | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc   |  |  |  | <del></del>                          | 10d. Inside City Limits  |
|   | r 28a-f ehow   | ecto                | Maryland <del>n/a</del> Harford <del>Baltimore</del>   | Bel Air  | 1017   | 10   | g. Citizen of Wh                     | 1 XYes 2 □ No  |
|   | E 9.75   | al Dir              | 10e. Street and Number 802 Coconut Court Apt. J<br>6419 Hilltop Avenue   | <del>21206</del>   | LO14   |  | U.S.A.                               |  |
| Q<br>930                                    | permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mentat Hygiane. Important: If item 27 is marked other than "natural", or Iteme 23a any Injury or other traumatic event, the Medical Examinat must angle.  | by Funeral Director | 4VThis and 4 The said 1 The State of | Was Decedent of Hispani<br>f Yes, specify Cuban, Me<br>I Yes 2 No Spe      | nic Origin? (Specify<br>exican, Puerto Rica<br>pecify: | Yes or No-<br>an, etc.)                      |                                      | American Indian,<br>White, etc.<br>White                         |
| [7.5036<br>215-0036                         | hin 72 ho<br>In "natur<br>Medical  | Completed           | (Specify only highest grade completed) (Give )   | dent's Usual Occupation<br>kind of work done during<br>DO NOT use retired) | g most of working                                      |  | 6b. Kind of Busin                    |  |
| 1213  | led with<br>lygiane<br>her tha   |                     | 12 years 6 years Teach   |  | Mathada Nama //  |  |                                      | e Public Schoo   |
| land  | ild be fil<br>fentat H<br>rked ott   | To Be               | 17. Father's Name (First, Middle, Last)  Vincent C. Kimball, Sr.   |  | Mother's Name (Fi                                      |  | alden Surname)                       |  |
| lary  | 2 should and he main   |                     |  | ng Address (Street and N   |  |  | •                                    |  |
| 3 5   | 1 and<br>Health<br>tem 27<br>other to  |                     | <b>7202</b>  | Hilltop Ave<br>sition (Name of<br>natory or other place)                   | Date   |  |                                      | ty or Town, State  |
|   | Pages<br>nent of<br>int: If It   |                     | 1 □ Burial 2 □ ▼Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  B/W Crema   |  | July 20  | 0, 2006                                      | 6 Balti                              | more, MD   |
| 07                   Baltimore. Maryland 21 | permit. Departm Importa any Inju   |                     | ral Home, Inc.<br>21206  |  |  |  |                                      |  |
|   | Physician  |                     | 23a. Parl . Enter the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Brain her  |  |  | espiratory arre                              | st,                                  | Approximate<br>Interval Between<br>Onset and Death               |
| nt ∪  | Cate be executed Examiner but and but and the prival-transit the prival-transit  | dicai Examiner      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):   | rebral he  | emore  | hage   |                                      | 18 hours   |
| O. Box 6                                    | To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: Atter this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the | by Physician/Med    |  | Ectopic pregnancy Other (specify)  |  |  | 23d. Date of Month                   | •  |
| \<br>\<br>P. P. P                           | quires that I  | d by Ph             | Part II. Other significant conditions contributing to death but not resulting in the un  | nderlying cause given in   | Part I.  |  |                                      | ute to the cause of death?                                       |
| <br>  Reco                                  | The law reate has bee  | Completed           |  |  |  | 24a. Was ar<br>autopsy<br>perform<br>1 Yes 2 | y prid<br>ned? dea                   | ere autopsy findings available or to completion of cause of ath? |
| Sit   | Physician:<br>this certific<br>ral director.   | Be                  | 25. Was case referred to medical examiner?  Hospital:  | Othor  | . Place of Death (C                                    |  |                                      |  |
| mi  | nding Phys. th. After this of funeral dir  | ition: To           | 1 Yes 2 No Hospital: 1 Inpatient 2 FNOutpatien  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  1 Inpatient 2 FNOutpatien  28a. Date of Injury (Month, Day Year)  28b. Time of Injury  | 1 3 DOA 4  |  |  | nce 6 Other w injury occurred        |  |
| Division                                    | Hospital or Attent<br>24 hours after deatl<br>Funeral Director:<br>itely filled in by the  | Certification;      | 3   Suicide 6   Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)   | eet, factory, office   | 28f  | . Location (Str<br>City or Town              | reet and Number<br>, State)          | or Rural Route Number,   |
| MLBSHA                                      | Hospital     24 hours 6     Funeral is letely filled   | Medical C           | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death only one)  1 Medical Examiner: On the basis of examination and/or in and manner stated.  | h occurred at the time, do<br>vestigation, in my opinion                   | date and place, and<br>on, death occurred              | due to the ca<br>at the time, da             | use(s) and manr<br>ate and place, an | ner as stated.<br>d due to the cause(s)                          |
| #   | To the I within 2 to the I complet   | Me                  | 29b. Signature and title of certifier  | 29c. License nun   |  | 25   |                                      | Month, Dey, Year)  |
|   | 9  |                     | · Casubul  |  | 3420   |  | July, 1                              | 8,2006   |
|   | 10   |                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Zubair Siddi?  |  |  |  |                                      |  |
| _   | St<br>Regist   | ate<br>rar          | 31. Date filed (Month, Day, Year) 2006 32. Registrar's Signature   | parti  | DEFECT OF  |  |                                      |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle. Year **Physician** 170 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AIRHENTHY REHABILITATION 7. Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth (Month, Day, 4-30 -9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 F **Funeral** Days 153-28-9564 Fiau Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla. Depertment of Health and Mental Hyglene. Important: if item 27 is marked other then "naturel; or items 23s or 28s-f ehov any injury or other treumelic event, the Medical Examinar must be notified at ADE. 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 220 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give 1 Newer Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Education eacher 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21015 20c. L. cation - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Evans Funeral Chape 8/06 Forest 4 ☐ Donation 5 ☐ Other (Specify) Funeral Chapel-BelAIR 21. Signature Fundral Service Licensee 22. Name and Address of Facility Evans Forest Hill 21050 MD Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mode **Physician** Non /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physiclan/Medical Examiner 12 After this certificate has been signed by the attending physicien and  $^{\times}$ tuneral director, pege 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certiticate be executed Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 W No 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Cher (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2×21No 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.
with Funeral Director: Attent his certificate has t completely tilled in by the funeral director. page 2 s autopsy performed? 2□ No 1 ☐ Yes 28 No 1 Tyes 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 4K Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 3□ DOA 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division 1 Alatural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 39a Centiller 115 Certifying Physiciam: To the best of my knowledge, death occurred at the time, date and place, and did to the nause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

10 State

Registrar

31. Date filed (Month, Day, Year)

سالات

JUL 2 1 2006

KHOSYA

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

206 HAYS ST #102 egistrar's Signature 32.

21014 MD BEL AIR

06

D56545

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item/10c.perFH.G857.7/21/06 III

|                     |   | •                    | Amend item#10c.p   | Maryland 7                       |                         | irtment of I                            |                        |                                 |                                       | giene 0                          | 06                      | 22                          | 908                |
|---------------------|---|----------------------|--|----------------------------------|-------------------------|---|------------------------|---------------------------------|---------------------------------------|----------------------------------|-------------------------|-----------------------------|--------------------|
| d                   |   |                      | Decedent's Name (First, Middle, Last)  |                                  |                         |   |                        | 2                               | 2. Date of Dea<br>Month               |                                  | Voor                    | 3. Time of                  | Death              |
| Н                   | Physici<br>/Medic   |                      | DORIS  |                                  |                         | LEV                                     | IN                     |                                 | JULY                                  | 18 2                             | 006                     | 12:40                       | ) A <sup>M</sup>   |
|                     | Examin  | _                    | 4a. Facility Name (If not institution, give street and number MILFORD MANOR NURSING HOMI   |                                  |                         | 4b. City, Town, o                       |                        | n of Death                      |                                       | 4c. Count                        | y of Death              |                             |                    |
|                     | Funeral<br>Director   |                      | 213-01-6550 1 <sup>1</sup> M 2/F   | Age (In yrs. last b<br>91        | oirthday)<br>Yrs.       | If Under 1 Year<br>Months Days          | If Und<br>Hour         |                                 | Date of Birth<br>Month, Day<br>7/04/1 | 915                              | 9. Birth<br>Cou         | place (State onto)<br>MD    | or Forei <b>gn</b> |
|                     | and w   |                      | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, To                    | wn or Lo                | cation                                  |                        |                                 |                                       |                                  |                         | 10d. Inside C               | ity Limits         |
|                     | Maryli<br>f eho   | lor                  | MD BALTIMORE   |                                  | ALTI                    | OMRE                                    | BALT                   | TMORE                           |                                       |                                  |                         |                             | a∏ No              |
|                     | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1   | Director             | 10e. Street and Number   |                                  | 77.12.11                | 10f. Zip Code                           |                        |                                 |                                       | l0g. Citizen of                  | What Cou                |                             |                    |
|                     | th with   |                      | 4204 OLD MILFORD MILL ROA  | D                                |                         | 2120                                    | 8(                     |                                 |                                       | U.                               | S.A.                    |                             |                    |
| 036                 | s 1 and 2 should be filed with n 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23s or 28s-f show other traumatic event, the Maryland Examiner must be nothing at | Completed by Funeral | 11. Marital Status  1 Never Married 2 Married  1 Vess Give  1 Vess Give  Year or Date  | s?<br>₹No                        |                         | Vas Decedent of I<br>f Yes, specify Cub |                        |                                 | fy Yes or No-<br>can, etc.)           | 14. Ra<br>Bla<br>Specia          | ick, White,             | can Indian,<br>etc.<br>HITE |                    |
| 2-0                 | 72 ho<br>natur  | eted                 | 15. Decedent's Education<br>(Specify only highest grade completed)   | 16                               | a. Deced                | lent's Usual Occup<br>kind of work done | pation<br>during m     | ost of working                  | ,                                     | 16b. Kind of E                   | Business/Ir             | ndustry                     |                    |
| 2121                | d within<br>giene.<br>er than "   | omple                | Elementary/Secondary (0-12) College (1-4)  | or 5+)                           | life. L                 | S WOMAN                                 | (d)                    |                                 |                                       | CLOT                             | THING                   |                             |                    |
| Maryland 21215-0036 | uld be file<br>fental Hy<br>rked oth  | To Be (              | 17. Father's Name (First, Middle, Last) BARNEY   |                                  | ABRA                    | MS                                      |                        | ther's Name (                   | First, Middle,                        | Maiden Sumai<br>GC               |                         | HEIDER                      |                    |
|                     | and 2 should<br>balth and Men<br>n 27 is marke<br>ier traumatic   |                      | 19a. Informant's Name/Relationship (Type, Print) GAIL SHUGARMAN / DAUGHTER   |                                  |                         | g Address (Street                       |                        |                                 |                                       |                                  |                         |                             |                    |
| re,                 | ges 1 and 2<br>it of Health<br>if Item 27 i   |                      | 20a. Method of Disposition   | coma                             | of Dispo                | sition (Name of<br>natory or other pla  | ce)                    | Da                              | te                                    | 20c. Location                    | - City or T             | own, State                  |                    |
| E                   | Pages<br>nent of<br>ant: if it<br>ury or o  |                      | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removat from Sta<br>4 ☐ Donation 5 ☐ Other (Specify)  |                                  |                         | H CONG.                                 |                        | 07/20/                          | 2006                                  | WOODLAW                          | IN, M                   | D                           |                    |
| Baltimore,          | permit. Pages Department of I Important: If Ite any injury or of  |                      | 21. Signatur of Funeral Service Licensee   |                                  |                         | Name and Address                        |                        | . SUI                           | LEVINS                                | ON & BE                          | ROS.,                   | INC.                        | 00                 |
|                     | 97 S  |                      | 23a. Part / Enter the disease, or complications that caus shock, or hearl failure. List only one cause on each   | sed the death. Do                | not ente                | or the mode of dy                       | ng, such               | as cardiac or                   | respiratory arr                       | est,                             | ,                       | Approximat<br>Interval et   | ween               |
| 111                 | Physician   |                      | Immediate Cause (Final disea e or condition resulting in death)  | gul                              | Stu                     | or ox                                   | me                     | nfin                            |                                       |                                  |                         | Third                       | MW)                |
|                     | /Medical<br>Examiner  |                      | Due to (or   | as a consequenc                  | e of):                  | 0                                       | 2.3.110.00.00          |                                 |                                       |                                  |                         |                             |                    |
| ×9.                 |   | - F                  | Sequentially list conditions, if any, leading to immediate Due to (or  | as a consequenc                  | e of):                  |   |                        |                                 |                                       |                                  | -                       |                             |                    |
| /                   | uted<br>d<br>ansit  | Examiner             | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  |                                  |                         |   |                        |                                 |                                       |                                  |                         |                             |                    |
| 0,                  | icate be executed<br>physician and<br>s the burial-transit  | Еха                  |  | as a consequenc                  | e of):                  |   |                        |                                 |                                       |                                  |                         |                             |                    |
| 8760,               | ate be  | dlcai                | d  |                                  |                         |   | _                      |                                 |                                       |                                  |                         |                             |                    |
| 9                   | certific<br>ding p  |                      | IF FEMALE: 23c. If yes, outcomes   | me of pregnancy                  |                         |   |                        |                                 |                                       | 224 D                            | ato of dollar           |                             |                    |
| Box                 | that the death certific<br>ed by the attending p<br>detached for use as   | cian                 | in the past 12 months?   | 2 Fetal dea<br>at time of death  |                         | Ectopic pregnanc<br>Other (specify) _   | У                      |                                 |                                       |                                  | ate of deliv<br>onth    | •                           | Year               |
| <u>о</u> .          | t the c<br>by the   | hysl                 | 9 Unknown 9 Unknown  | 1                                |                         |   |                        |                                 |                                       |                                  |                         |                             |                    |
| Records, F          | 8 5 G   | d by Physician/Me    | Part II. Other significant conditions antibuting to deat  When the significant conditions and the significant conditions and the significant conditions and the significant conditions and the significant conditions and the significant conditions and the significant conditions and the significant conditions and the significant conditions and the significant conditions and the significant conditions and the significant conditions and the significant conditions and the significant conditions and the significant conditions and the significant conditions are significant conditions. | n but not resulting              | in the ur               | nderlying cause gr                      | ven in Pa              | rt I.                           |                                       | bacco use con<br>es 2 □No        |                         | the cause of c              |                    |
| Ö                   | aw requir<br>as been si<br>2 should   | Completed            | ( hose t   | en (ISM                          |                         |   |                        |                                 | 24a. Was a                            | n 24b.                           | Were auto               | opsy findings               | available          |
| <u> </u>            | nysician: The lav<br>nis certificate has<br>I director, page 2 a  | mo                   | 117  |                                  |                         |   |                        |                                 | autops<br>perfor                      | med?                             | death?                  | ompletion of c<br>2□ No     | ause or            |
| Vital               | sian:<br>artifica<br>octor, I   | ВеС                  | 25. Was case referred to medical examiner?   |                                  |                         |   |                        | ce of Death (                   | Check only or                         |                                  |                         |                             |                    |
| 5                   | Physic<br>this contains and dire  | 2                    | 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inp   |                                  |                         | 1 3 DOA                                 |                        |                                 |                                       | ence 6 Otl                       |                         | fy)                         |                    |
| no                  | ding F<br>h.<br>After<br>funer  | tion                 | TENTAL SET STORY   | Day Year)                        | . Time of<br>Injury     | 28c. Inju<br>Wo                         | ryat<br>rk?<br>]Yes 2  |                                 | d. Describe n                         | ow injury occui                  | rrea                    |                             |                    |
| Division of         | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.   | Certification:       | 3 Suicide 6 Could not be 28e. Place of   | Injury - At home, etc. (Specify) | farm, stre              |   |                        |                                 | f. Location (S<br>City or Tow         | treet and Num<br>n, State)       | ber or Run              | al Route Num                | nber,              |
| Ω                   | urs af<br>aral D  |                      |  |                                  |                         |   |                        |                                 |                                       |                                  |                         |                             |                    |
|                     | To the Hospital within 24 hours a To the Funeral I completely filled  | Medical              | 29a. Certifier 1 Certifying Physicien: To the be (Check only one) 2 Medical Exeminer On the basi and manner  | s of examination a               | ge, death<br>and/or inv | restigation, in my                      | me, date<br>opinion, d | and place, an<br>leath occurred | d due to the d<br>I at the time, o    | ause(s) and m<br>late and place, | anner as s<br>and due t | stated.<br>o the cause(s    | 5)                 |
|                     | To the within To the complex  | Me                   | 29b. Signature and title of certifier  | n                                |                         | 29c. Licen                              | se numbe               | er                              | 2                                     | 9d. Date signe                   | ed (Month,              | Dey, Year)                  |                    |
|                     |   |                      |  |                                  | 1                       | 27                                      | 569                    |                                 | 71                                    | 181                              | 06                      |                             |                    |
|                     | 3   |                      | 30. Name and address of person who completed cause of  | 10.                              |                         | Print)                                  | 36                     | Gree                            | ne T                                  | ree                              | RI                      | #3                          | 00                 |
| (6)                 | Sta   | te                   | 31. Date filed (Month, Day, Year) 32. Rec  | -                                | la .                    | parte                                   | · U                    |                                 |                                       | ·ul                              | V-7/                    |                             |                    |
|                     | Registr   | ar                   | 1111 9 1 2006  | Carren 1                         | K X                     | WOOM!                                   |                        |                                 |                                       |                                  |                         |                             |                    |

|         | ÷.   | A e le  | 638                        | 1 - For Amend item#1, pressure Registrar  1. Decedent's Name (First, Middle, L   |   |                               | Certifica                      | ile OI D                       | calli                             | 2. Date of Dea                       | ath                         | V -                      | 3. Time of Death                             |
|---------|--|---|----------------------------|--|---|-------------------------------|--------------------------------|--------------------------------|-----------------------------------|--------------------------------------|-----------------------------|--------------------------|--|
|         |  | Physici<br>/Medic   |                            | BETTY  | Detrye 143  |                               |                                | ESTER                          |                                   | Month<br>July                        | 18, 2L                      | Year<br>06               | 5:39 PM                                      |
|         |  | Examir  |                            | 4a. Facility Name (If not institution, go  | /   | · 110 000                     | 4b. Ci                         | -                              | ocation of Deat                   | h                                    | 4c. Count                   |                          |  |
|         | 200  |   |                            | 5. Social Security Number 6.   |   | UCDIC<br>(In yrs. last bir    | thday) If Uno                  |                                | IMORE If Under 24 Hrs             | - R Date of Birth                    | h                           |                          | I/A  |
|         |  | Funeral<br>Director   |                            | 217-09-5564  | 1□ M 20 F   |                               | Yrs. Month                     |                                | Hours Min.                        | 8. Date of Birt (Month, Day 04/14/1  | 920                         | Cour                     | place (State or Foreign htry)  MD            |
| KE      | pue  | A sa  |                            | Usual Residence of Decedent  10a. State 10b. County  | 1   | 10c. City, Town               | n or Location                  |                                |                                   |                                      |                             | 1                        | Od. Inside City Limits                       |
| 11      | M  | a-f ehc   | ctor                       | MD BALTI   | MORE  | ВА                            | LTIMOR                         | Ξ                              |                                   |                                      |                             |                          | 1 ☐ Yes <b>¾</b> ☐ No                        |
| BE      | 1215-0036 with its Maryland  | rai', or iteme 23a or 28a-f ehow<br>Examiner must be notified at  | Funeral Director           | 10e. Street and Number 725 MT. WILSON  | LANE  |                               | 10f. i                         | Zip Code<br>21208              |                                   |                                      | 10g. Citizen of U.S         |                          | ntry?  |
| ~       | er dea   | Heme<br>Digerme   | uner                       | 11. Marital Status   | 12. Was Decedent E<br>Armed Forces?   |                               | 13. Was Dec<br>If Yes, s       | edent of Hisp<br>becify Cuban, | panic Origin? (S<br>Mexican, Puer | pecify Yes or No-<br>to Rican, etc.) | 14. Ra                      | e - Americ<br>ck, White, |  |
| ESTER   | 215-0036   | al', or   | b                          | 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 📉 No<br>If Yes, Give<br>Year or Dates:                                | 0                             | 1 ☐ Yes                        | 2 No                           | Specify:                          |                                      | Specif                      | . WHI                    | TE   |
| 5       | 5-0  | "natural",  | eted                       | 15. Decedent's E<br>(Specify only highest g  | Education rade completed)   | 16a.                          | Decedent's U:<br>(Give kind of | vork done du                   | ion<br>ring most of wo            | rking                                | 16b. Kind of B              | usiness/Ind              | dustry                                       |
| 1       | 2121<br>gwithin  |   | Completed                  | Elementary/Secondary (0-12)  | College (1-4or 5-   | ь) ВО                         | OKKEEPI                        | use retired)                   |                                   | 2                                    | LESTER                      | FOOD                     | MARKET                                       |
|         | ਹ 🖁  | d at  | To Be C                    | 17. Father's Name (First, Middle, Las FRANK  | rt)   |                               | SHURKII                        |                                | 8. Mother's Nar<br>ROSE           | me (First, Middle,                   |                             | AMER                     |  |
| 8       | Marylan de should be   | and<br>s m  | F                          | 19a. Informant's Name/Relationship   | (Type, Print)   | 19b.                          | Mailing Addre                  | ss (Street an                  | d Number or Ru                    | ıral Route Numbe                     | r, City or Town             | State, Zip               | Code)  |
| KNOWN   |  | Healt<br>em 2<br>ther   |                            | HAROLD LESTER /<br>20a. Method of Disposition  | HUSBAND   |                               | 25 MT. Disposition (A          |                                | N LANE                            | - BALTIM                             |                             |                          |  |
| 3       | mor  | 7 - 7   |                            | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec  |   | cemeter                       | y, crematory o                 | other place)                   | 07/2                              | 21/2006                              | BALTI                       |                          |  |
| Patient | Baltimore,   | Deparment of Important: If any in ury or ance.  |                            | 21. Signature of Funeral Service Lice  |   |                               | 22. Name                       | and Address                    |                                   | OL LEVIN                             |                             |                          |  |
| 2       |  |   |                            | 23a. Part Forter the disease, broom  | nulications that caused t   | the death. Do n               | 8900                           | REISTI                         | ERSTOWN                           | ROAD -                               | PIKESVI                     |                          |  |
|         |  | nysician  |                            | 23a. Part . Enter the disease, broomshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) | yone cause on each line - a. Powerce  |                               | auses                          | out of aying,                  | Sub-rad sarara                    | or respiratory an                    |                             | 6                        | Interval Between<br>Onset and Death          |
| _       |  | Medical xaminer   |                            | 1  | Due to (or as a   | consequence                   | of):                           |                                |                                   |                                      |                             | 17                       | 0 40.  |
|         | P  | slt   | iner                       | Sacual tiefly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                            | Due to or as a  | consequence of                | of):                           |                                |                                   |                                      |                             | •                        | <i></i>                                      |
|         | 760, <   | ician and<br>burial-transit   | Examiner                   | that initiated events resulting in death) Last   | c. Due to (or as a  | consequence of                | of):                           |                                |                                   |                                      |                             | -                        | · · · · · · · · · · · · · · · · · · ·        |
|         | 760,   | ysiciar<br>ne buris   | cal                        |  | d   |                               |                                |                                |                                   |                                      |                             |                          |  |
|         | x 68   | attending phy   | Med                        | IF FEMALE:   |   |                               |                                |                                |                                   |                                      |                             |                          |  |
|         | Division of Vital Records, P.O. Box 68 or of the death certification of the | within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending phi<br>completely itiled in by the funeral director, page 2 should be detached for use as th | Completed by Physician/Med | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown   | 23c. If yes, outcome o<br>1 ☐ Live birth 2<br>4 ☐ Pregnant at ti<br>9 ☐ Unknown | Fetal deeth                   | 3 ☐ Ectopic<br>5 ☐ Other (     |                                |                                   |                                      |                             | te of delive<br>nth      | ry<br>Day Year                               |
|         | IS, P  | signed b  | by PI                      | Part II. Dther significant conditions DEMENTE CA   |   | t not resulting in            | the underlying                 | cause given                    | in Part I.                        |                                      |                             |                          | e cause of death?                            |
|         | Corc   | should  | leted                      | Derrentie ; on   |   |                               |                                |                                |                                   | 24a. Was a                           | es 2 No                     |                          |  |
|         | I Re   | page 2  | Somp                       |  |   |                               |                                |                                |                                   | autops<br>perfori                    | med?                        | leath?                   | osy findings available inpletion of cause of |
|         | Vita<br>ician:   | ector,  | Be                         | 25. Was case referred to medical examiner?   | Hospital:   |                               |                                | 7                              |                                   | th (Check only or                    |                             |                          |  |
|         | Phys   | h.<br>After this certific<br>funeral director,  | . To                       | 1 ☐ Yes 2/2(No<br>27. Manner of Death  | 28a. Date of Injury<br>(Month, Day  |                               | ime of                         | 28c. Injury at                 | 4   Nursing H                     | ome 5 Reside                         |                             |                          | )  |
|         | ion  | oath.<br>or: Afte   | ation                      | → Natural 5 Pending 2 Accident investigation   | on  | Year) In                      | jury<br>M                      | Work?                          | s 2 🗆 No                          |                                      | , ,                         |                          |  |
|         | Divis  | after de<br>Directe<br>d in by t  | Certification:             | 3 Suicide 6 Could not to determined  |   | y - At home, far<br>(Specify) | m, street, facto               | ry, office                     |                                   | 28f. Location (St<br>City or Town    | treet and Numb<br>n, State) | er or Rural              | Route Number,                                |
|         | Hospita  | within 24 hours after deat<br>To the Funeral Director:<br>completely tilled in by the   | edicai C                   | 29a. Certifier Check only one)   | hysician: To the best of<br>miner: On the basis of e<br>and manner state        | axamination and               | Vor investigatio               | ומומס עומ מו מ                 | ion death occur                   | rrad at the time d                   | ate and place               | nner as sta              | ated.<br>the cause(s)                        |
|         | To the   | within<br>To the<br>comple  | Me                         | 29b. Signature and title of certifier  |   |                               | 2                              | 9c. License n                  | umber                             | 2                                    | 9d. Date signe              | i (Month, E              | Day, Year)                                   |
|         |  |   |                            | · gBredersk  | cite, MD  |                               |                                | RES-                           | -000                              | 1                                    | July 1                      | 8,20                     | 2006   |
|         |  | 5   |                            | 30. Name and address of person who   | completed cause of dea  | ath (Item 23a) (              | Type, Print)                   | rei He                         | ospétal é                         | ot Bolt                              | "Cleor                      |                          |  |
|         |  | Sta<br>Registr  |                            | 31. Date filed (Month, Day, Year)  JUL 2 1 2   | and manner state  CEL HID  completed cause of dea  CSEA 1775 (1)  32. Pigistran | 's Signature                  | Sports                         | ,                              | <del>,</del>                      |                                      |                             |                          |  |

LESTER, BETTYE

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CATHERINE **Physician** MECREADY Month 9-2006 12.04AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bon Secours Hospital Baltimore n/a 7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

7. Age (In yrs. last birthday)

Months Days Hours Min. 5/8/1932 5. Social Security Number 215-28-4434 6. Sex **Funeral** 9. Birthplace (State or Foreign 1□ M 2X F Director MaryTand Usual Residence of Decedent 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "neturel", or Items 23e or 28e-1 shov other traumatic event, the Middical Exam are must be coulded as MD n/a Be Completed by Funeral Director Baltimore 1 XYes 2 No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 532 Catherine St. 21223 United States 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nursing Aid Elder Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be 1 ment of Health and Mental I ent: If Item 27 is marked of Thomas Lucas Gertrude Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Meyer / son-in-law 1523 Timan Circle Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ö 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. West Arundel Crematory 7/22/2006 Odenton, Maryland 4 □ Donation 5 □ Other (Specify) 21. Sign vu e of Funer 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd Baltimore, Maryland 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final **Physician** HEUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARTERY DISEASE DRONARY SEVERAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its today and in the cause of th Examiner Due to (or as a consequence of) ed by the attending physicien end detached for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 PNo Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ ESSENTIAL HYPERTENSION, TYPE IT DIARETER 1 Pres 2 No 3 Probably 4 Unknown Be Completed MELLITUS, OLD STROKE, CHRONIC OBSTRUCTA Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? LUNG DISEASE, PARKINSON'S DISEASE 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 3 DOA After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending within 24 hours after death, To the Funeral Director: A investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: / 6 Could not be 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lez am no D18362 7/19/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). 3455, Wilkers Ave. Suite LL10, Balto, Md21229 Komal K. Dang m. D.

31. Date filed (Month, Day, Year)

JUL 2 1 2006 Hegistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend items / 8.17 per fh 8857 7-21-06 vt
State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 2 2 2 1

|                   |  |                   | 1 - For<br>State<br>Registrar  | Otate of Ivial                                   |                         | ertificate of                               | Death   | Reg. No.                             |                                    | 44911  |
|-------------------|--|-------------------|--|--|-------------------------|---|---|--------------------------------------|------------------------------------|--|
|                   |  |                   | 1. Decedent's Name (First, Middle, Las   |  | 1                       |   |   | . Date of Death                      |                                    | 3. Time of Death                               |
|                   | Physici<br>/Medio  |                   | PATTIE   | 7  | Mc G                    | EE  |   | JUly 17                              | - 2006                             | 9:09AM   |
|                   | Examir   |                   | 4a. Facility Name (If not institution, give  | street and number)                               | TAI                     | 4b. City, Town, o                           | or Location of Death                              |                                      | County of Death                    |  |
|                   |  |                   | Northwest  | HOSDI  | 1 1/1                   | KANO  | Allslow   |                                      | <u> </u>                           | more_  |
|                   | Funeral<br>Director  |                   | 5. Social Security Number 6. S.  124-42-22/7  Usual Residence of Decedent                                  | ex<br>□ M 2/2€F 7.Age (                          | In yrs. last birtho     | Months Days                                 | If Under 24 Hrs. 8<br>Hours Min.                  | Date of Birth<br>(Month, Day, Year)  | 49 9. Birthp<br>Cour               | place (State or Foreign<br>http)<br>EW York    |
|                   | ow ow  |                   | 10a. State 10b. County   | 1  | Oc. City, Town o        | Location                                    |   |                                      | 1                                  | Od. Inside City Limits                         |
|                   | Mary<br>First  | to                | Mn Bolt  | more   | C                       | was och                                     | $\nu$   |                                      |                                    | 1 Yes 2 No                                     |
|                   | h the  | irec              | 10e. Street and Number   |  | Ou                      | 10f. Zip Code                               |   | 10g. Citi                            | izen of What Cour                  | ntry?  |
|                   | th wit   | aD                | 6315 Mor   | rika Pla   | ace                     | 212   | 07  |                                      | USA                                |  |
|                   | r dee  | Funeral Director  | 11. Marital Status   | 12. Was Decedent Eve<br>Armed Forces?            | er in U.S.              | 3. Was Decedent of I<br>If Yes, specify Cub | Hispanic Origin? (Speci<br>an, Mexican, Puerto Ri | fy Yes or No-<br>can, etc.)          | 14. Race - Americ<br>Black, White, |  |
| 21215-0036        | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "neturel" or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at once.                                   | þ                 | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced   | 1 X Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates: |                         | 1 ☐ Yes 2 No                                | Specify:  |                                      | Specify: 77                        | ick  |
| 7                 | n 72 h   | ete               | 15. Decedent's Ed<br>(Specify only highest gra   | ucation<br>de completed)                         | (G                      | ive kind of work done                       | during most of working                            | 16b. Ki                              | ind of Business/In                 | dustry   |
| 12                | withir<br>ane.<br>then   | Completed         | Elementary/Secondary (0-12)  | College (1-4or 5+)                               |                         | e. DO NOT use retire<br>Lealth C            | ,   | 1                                    | 1 +                                | - 1  |
| d<br>2            | Hygie<br>Hygie<br>other  | ပိ                | 17. Father's Name (First, Middle, Last)  | <u>~</u>   |                         | realth C                                    | 18. Mother's Name (                               | First, Middle, Maiden                | Sumame)                            | 2  |
| Maryland          | Mental<br>Mental<br>arked o  | To Be             | Elsway Shula (   | cole   |                         |   | Martha  | - 1                                  | 0/1                                |  |
| 3L                | 2 should be<br>and Mental<br>le marked of<br>aumatic eve   | -                 | 19a. Informant's Name/Relationship (7  | Type, Print) [5c                                 | 19b. M                  | ailing Address (Street                      | and Number or Rural I                             |                                      |                                    | Code)  |
|                   | 1 and 2<br>Health a<br>tem 27 le   |                   | John Mc Gee  |  | 53                      | 7 Broad                                     | St. Meri  | den Con                              | D                                  |  |
| e,                | of Head  |                   | 20a. Method of Disposition   |  | 20b. Place of Di        | sposition (Name of crematory or other pla   | Dat   | 7-1-                                 | ocation - City or To               | own, State                                     |
| Ē                 | Pages<br>nent of t<br>ant: If It<br>ary or o   |                   | 1 ☐ Burial 2 🔀 Cremation 3 🗷 1 ☐ Donation 5 ☐ Other (Specify   |  |                         |   | . 1   | 1-2006 Ha                            | rteda le                           | NV   |
| Baltimore,        | permit. Pages 1 ar<br>Department of Hea<br>Important: if Item<br>any injury or other<br>once.  |                   | 21. Sonature of Funeral Service Licen  | see  |                         | 22. Name and Addre                          | as of Facility                                    | al Home F                            | A                                  | 1  |
| <u> </u>          | 82529  | 0                 | poseph J. tu   | SS   |                         | 2212W.NO                                    | 57-25<br>EUSS Funer<br>orth Ave. Ba               | HIMORE, A                            | 1d. 212                            | 14   |
|                   |  |                   | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only                               | dications that caused the                        | e death. Do not         | enter the mode of dyi                       | ng, such as cardiac or                            | espiratory arrest,                   |                                    | Approximate<br>Interval Between                |
|                   | Physician  |                   | Immediate Cause (Final disease or condition  | . CONG   | estiv                   | e Hear                                      | RT FAIL   | URE                                  |                                    | Onset and Death                                |
| E                 | /Medical<br>Examiner   |                   | resulting in death)  | Due to (or as a d                                | onsequence of):         |   |   |                                      |                                    |  |
| U                 |  | _                 | Sequentially list conditions,  | b. Due to (or as a c                             | consequence of)         |   |   |                                      |                                    |  |
| T                 | led<br>sit   | ulue              | Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury | Due to (or as a c                                | onsequence or):         |   |   |                                      |                                    |  |
| Ĭ.                | and and  | Examiner          | that initiated events resulting in death) Last   | C. Due to (or as a c                             | consequence of):        |   |   |                                      |                                    |  |
| 68760,            | rificate be executed ng physicien and as the burial-transit  |                   |  | d  |                         |   |   |                                      |                                    |  |
| 89                | tificat<br>g phy<br>as th  | ed                |  |  |                         |   |   | ======                               |                                    |  |
| ŏ                 | th cer<br>endin  | Physician/Medical | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome of 1 Live birth 2           |                         | 3 □Ectopic pregnanc                         | v   | 2                                    | 23d. Date of delive                | •  |
| P.O. Box          | w requires that the death cer<br>been signed by the attendir<br>should be detached for use   | slcle             | in the past 12 months? 1 Yes 2 No  | 4□Pregnant at tin                                |                         | 5 Other (specify)                           | ,   |                                      | Month                              | Day Year                                       |
| <u>Ч</u>          | at the   | Phy               | 9 Unknown  |  |                         |   |   |                                      |                                    |  |
|                   | res th   | by                | Part II. Other significant conditions of   | onthouting to death but i                        | not resulting in th     | e underlying cause giv                      | ven in Part I.                                    | 23e. Did tobacco u                   |                                    | 1/   |
| 9                 | requi  | eted              | 201  |  |                         |   |   | 1 Yes 2                              | □No 3□ Prob                        | ably 4 Munknown                                |
| Records,          | e law<br>has b   | Completed         | Diabetes   |  |                         |   |   | 24a. Was an autopsy                  | prior to cor                       | psy findings available<br>npletion of cause of |
| a                 | n: Th<br>icate<br>r. pag   |                   |  |  |                         |   |   | performed?<br>1□ Yes 215 No          | death?                             | 5000   |
| Division of Vital | siciar   | Be                | 25. Was case referred to medical examiner?   | Hospital:  | N-                      | Ott   | 26. Place of Death                                |                                      |                                    |  |
| o                 | Physic rubis oral di   | . To              | 1 ☐ Yes 2 ☑ Mo<br>27. Manner of Death  | 28a. Date of Injury                              | 2 X FVOutpa<br>28b. Tim | tient 30 DOA                                | 4 1 ladising Home                                 | 5 Residence 6 d. Describe how injury |                                    | /)   |
| on                | rding<br>th:<br>: Afte   | tlor              | Natural 5 Pending 2 Accident investigation   | (Month, Day Y                                    | 'e <i>ar)</i> Inju      | y Wo  | rk?<br> Yes 2 □ No                                |                                      |                                    |  |
| <u>S</u>          | If or Attendiates death.  Director: A din by the fu  | ifica             | 3 Suicide 6 Could not be determined  | 286. Place of injury                             | At home, farm,          | street, factory, office                     | 28  | Location (Street and                 |                                    | l Route Number,                                |
| ā                 | s afte   | Certification:    | 4 El Homode  | building, etc.                                   | эр <del>в</del> спу)    |   |   | City or Town, State)                 | ,                                  |  |
|                   | lospit<br>hour<br>unera  | ledical           | 29a. Certifier Certifying Ph   | ysicien: To the best of a                        | ny knowledge, d         | eath occurred at the til                    | me, date and place, and                           | d due to the cause(s)                | and manner as st                   | ated.  |
|                   | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medi              | one)   | and manner state                                 | d.                      |   |   |                                      |                                    |  |
|                   | To<br>To   | <                 | 29b. Signature and title of Terms r  | 010.15   | - '0                    | 29c. Licens                                 |   | 29d. Date                            | e signed (Month, I                 | Day, Year)                                     |
| •                 | r  | - 51              | 1 grand  | 12 NA 21   | CIAN                    | 1)00  | 325750  | 101                                  | 4 1+                               | 2006   |
|                   | 6  |                   | 30. Name and a dress of person who   | completed cause of dea                           |                         | 00, Print)<br>540( 010                      | d Court   | Rd PAI                               | dollatan                           | 21135  |
|                   | Sta  | te                | 31. Date filed (Month, Day, Year)  | 32. Spistrar's                                   | Signature               | A   | of cooks !  | IN MIN                               | ca (1) 10 ac                       | עוייע  |
|                   | Registr  |                   |  | 006  | JK,                     | Coule                                       |   |                                      |                                    |  |
| Di                | MH 17 Pov 1/2  | 201               | 00L 2 - L  |  |                         | /   |   |                                      |                                    |  |

|               |  |   | 1 - For<br>State<br>Registrar  | State of Ma  | arylan                    | •                                      |                                   |                            | ealth a<br>Death                      | and Me                     | -                                       | giene<br>Reg. No       | 201                              | )6                           | 229  | 112               |
|---------------|--|---|--|--|---------------------------|--|-----------------------------------|----------------------------|---------------------------------------|----------------------------|---|------------------------|----------------------------------|------------------------------|--|-------------------|
|               | Physici<br>/Medic<br>Examin  | al  | Decedent's Name (First, Middle, Lase Russell Lowell Mc.      Aa. Facility Name (If not institution, give | Kay  |                           |  | 4b. City                          | Town, or                   | Location o                            |                            | 2. Date of De<br>Month<br>July          | Da<br>1                | 8 2                              | 006<br>Death                 | 3. Time of Do                                      |                   |
|               | Funeral<br>Director  |   | Gilchrist Center  5. Social Security Number  240-20-1932   | ex 7. Age  | e (In yrs. i              | ast birthday)<br>Yrs.                  |                                   | OWSOII<br>r 1 Year<br>Days | If Under 2<br>Hours                   | Min.                       | 8. Date of Bir<br>(Month, Da<br>larch 1 |                        |                                  |                              | e<br>ce (State or F<br>y)<br>ch Caro               |                   |
|               |  | tor   | Usual Residence of Decedent  10a, State 10b, County  Maryland N/A  |  | 10c. City                 | y, Town or Lo                          |                                   |                            |                                       | E                          | arch 1                                  | .0,                    | 1921                             |                              | d. Inside City                                     | Limits            |
|               | death with the Maryland<br>ims 23s or 28s-1 show<br>ir must be notilised at  | Funeral Director  | 10e. Street and Number<br>6225 York Rd., Ap  | t. E415  |                           |  |                                   | Code 21212                 | 2                                     |                            |   |                        | izen of Wh                       |                              | -  |                   |
| <b>2-0036</b> | s after  | Ď   | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced                                | 12. Was Decedent I<br>Armed Forces?<br>1 Yes 2 X<br>If Yes, Give<br>Year or Dates: |                           |  | Was Dece<br>f Yes, spe<br>l ☐ Yes |                            | spanic Orig<br>n, Mexican<br>Specify: | gin? (Spe<br>n, Puerto F   | cify Yes or No<br>Rican, etc.)          | )-                     | 14. Race -<br>Black,<br>Specify: | American<br>White, et<br>Bla | c.   | ıl                |
| 0-61212       | filed within 72 hour<br>Hygiene.<br>Ither then "natural<br>ent, the Micolcel Ex  | Completed   | 15. Decedent's E<br>(Specify only highest gra<br>Elementary/Secondary (0-12)                             | ducation<br>de completed)<br>College (1-4or 5                                      | i+)                       | 16a. Deced<br>(Give<br>life. L         | kind of w<br>DO NOT i             | ork done d<br>ise retired  | during most<br>)                      | t of workin                | g                                       |                        | ind of Busin                     |                              | istry  |                   |
| Maryland      | ould be file<br>Mental Hy,<br>arked othe   | To Be C   | 17. Father's Name (First, Middle, Last)<br>unknown   |  |                           |  |                                   |                            |                                       |                            | (First, Middle,<br>y McKa               |                        | Sumame)                          |                              |  |                   |
| _             | s 1 and 2 she<br>f Health and<br>ftem 27 is m<br>other traum   |   | 19a. Informant's Name/Relationship (Carolyn McKay Oak 20a. Method of Disposition                         |  |                           | 19b. Mailin<br>10 Ch:<br>lace of Dispo | rist                              | ians                       | Dr.                                   | Han                        | Over,                                   | PA                     |                                  |                              |  |                   |
| Baltimore,    | artment o<br>ortent: If<br>injury or   |   | 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service, Licer      | y)   |                           | enmoun                                 | nt cr                             | emate                      | ory Ji                                |                            | 4,2006<br>eld Fu                        | Ва                     | 1timo                            | re,                          | Maryla   | nd                |
| ñ             | Depti<br>fimbe   |   | 23a. Jart1. Enter the disease, or com<br>shock, or heart failure. List only                              | one cause on each lir  | 10.                       | h. Do not ent                          | er the mo                         | de of dyin                 | g, such as                            | cardiac or                 | eld Fui<br>Baltii<br>respiratory a      | nera<br>more<br>rrest, | , MD                             | 1                            | 12<br>Approximate<br>nterval Betwe<br>Onset and De |                   |
| 8760,         | Physician /Medical Examiner who priviled the priviled form of the privil | resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of): |  |  |                           |  |                                   |                            |                                       |                            |   |                        |                                  | 4                            | peek   |                   |
| O. Box 6      | of the death certificate<br>by the attending phys<br>teched for use as the   | Physician/Med   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                  | 23c. If yes, outcome<br>1 Live birth<br>4 Pregnant at<br>9 Unknown                 | 2 Feta                    | Ideath 3□                              | Ectopic p                         |                            |                                       |                            |   |                        | 23d. Date (                      | ,                            | /<br>∂ay Yea                                       | ar                |
| ecords, P.    | law requires thet the<br>as been signed by th<br>2 should be deteche   | ٥   | Part II. Other significant conditions of   | ontnbuting to death b  | ut not res                | ulting in the ur                       | nderlying                         | cause give                 | en in Part I.                         |                            |   | obacco<br>Yes 2        |                                  | ute to the                   | cause of dea                                       |                   |
| r             | The<br>ste h<br>page   | Completed   |  |  |                           |  |                                   |                            |                                       |                            | 24a. Was<br>auto<br>perfo<br>1 Yes      |                        | pridea                           | or to comp<br>ath?           | sy findings av<br>pletion of cau                   | ailable<br>ise of |
| Vital         | sician: Th<br>certificate<br>rector, pag   | Be  | 25. Was case referred to medical examiner?   | Hospital:  |                           |  |                                   | Oth                        | 00                                    |                            | (Check only o                           |                        | -                                |                              | 1  | _                 |
| Division of   | iding Physith.<br>th.<br>After this funeral di   | tlon: To  | 1 Yes 25 No  27. Manner ol Death 1 Natural 5 Pending investigation                                       | 28a. Date of Inju<br>(Month, Da  |                           | ER/Outpatien<br>28b. Time of<br>Injury |                                   | 28c. Injun<br>Worl         | 4 🗀 Nu                                | 2                          | ne 5□ Resi<br>8d. Describe              |                        | occurred                         |                              | NOSF   | 06.60             |
| Divisi        | To the Hospitel or Attending Physicien: within 24 hours effer death. To the Funerel Director: After this certificacompletely filled in by the funeral director,  | Certification:  | 3 Suicide 6 Could not be determined  | e 28e. Place of Injubulding, etc   | ury - At ho<br>c. (Specif | ome, larm, str<br>y)                   | eet, lacto                        | y, office                  |                                       | 2                          | 8l. Location (<br>City or To            | Street ar<br>wn, State | nd Number<br>e)                  | or Rural i                   | Route Numbe  | er,               |
|               | To the Hospitel within 24 hours (To the Funerel completely filled  | Medical   | (Check only 2 Medical Examone)   | niner: On the basis of<br>and manner sta   | f examina                 | wiedga, daath<br>tion and/or in        | vestigatio                        | a, in my o                 | pinion, dea                           | id place, a<br>ith occurre | nd due to the<br>d at the time,         | date an                | d place, an                      | d due to t                   | he cause(s)  |                   |
|               | To With  | 2   | 29b. Signature and title of certifier  | Inus   |                           |  | - 1                               |                            | a number                              | 53                         |   | - 4                    | te signed (                      |                              | * . ,  |                   |
| _             | N  |   | 30. Name and address of person who   | rances in  | n be                      | 601 N                                  | Print)                            | uru                        | y SI-                                 | B                          | remi                                    | Y                      | m                                | 2120                         | 4  |                   |
|               | Sta<br>Regist  |   | 31. Date filed (Month, Day, Year)  | 32. Rigistr  | ars Signa                 | B A                                    | medi                              |                            |                                       |                            |   |                        |                                  |                              |  |                   |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Month **Physician** 7,000 Tercier 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Husp.tu If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 □ E Director 217-58-0558 84 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatih and Mental hygiene. ant: If item 27 is marked other than "natural", or itsma 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or itsma 23a or 28a-f show traumatic evant. The Medical Examinar must be notified at 1 Yes 2 No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2963 Normandy Drive <u> 21043</u> Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 William Sullivan Bridgette McGeever 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maurice W. Mercier/Husband 2963 Normandy Drive Ellicott City, MD 21043 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 5 permit. Page Department of Important: If any injury or Metro Crematory, Inc. 7/21/06 Baltimore, MD 21. Signature of Funeral Service Licenses Cremation Society of Maryland, Inc. Todd Dring 299 Frederick Rd Baltimore, MD 21228 23a. Part1. Enter the disease, or complica on that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one use on soft line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** creek /Medical Doe to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner g physician and The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy lor in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No be detached o 9 Unknown 9 Unknown ģ Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has this certificate 2 No 1 ☐ Yes 1 🗌 Yes 2 2 No the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 9 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After To the Hospital or Attanding 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a, Certifier 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Registrar's Signature 31. Date filed (Month, Day, Year) State 1 2006 Registrar

| A Facily Name   Fore vertication, give speak and number  |                |  |              | 1 - For<br>State<br>Registrar   | State of Marylan                                      |                                   | tment of l        |   |                                   | giene<br>Reg. No.    | 2006            | 22914                   |
|--|----------------|--|--------------|---|---|-----------------------------------|-------------------|---|-----------------------------------|----------------------|-----------------|-------------------------|
| SOUTHERN MARYLAND HOSPITAL CENTRE CLINTON  SOUTHERN MARYLAND HOSPITAL CENTRE CLINTON  SOUTHERN MARYLAND HOSPITAL CENTRE CLINTON  214-36-3704  1.5 Sand Share |                | Physici                                  | an           |   | M MED   | T.EV                              |                   |   |                                   |                      | 2/80            | 3. Time of Death        |
| SOUTHERN MARYLAND HOSPITAL CENTER CLINTON  Southern Management of the County of the Co |                |  |              |   |   |                                   | 4b. City, Town,   | or Location of Dea                        |                                   | 4c.                  | County of Death | 1                       |
| 214-36-3704   104 20   67 vs.   Months   Days   Hours   Mo.   Mol.   M   |                |  |              |   |   |                                   |                   |   |                                   |                      |                 |                         |
| Description      |                |  |              |   | MA 2DE  | ,,                                |                   |   | (Month, Da                        | v Yearl              | Chi             | intry)                  |
| Corneilius Medley  Corneilius Medley  19b. Mailing Address (Street and Number or Putal Pouts Number City or Town, State, Zip Code)  Patricia Medley / Daughter 10501 Joyceton Dr. Upper Marlboro, Md.  20b. Place of Deposition  1 Burst 2 (Disposition 1 Burst 2 (Disposition 1 Burst 2 (Disposition 1 Burst 2 (Disposition 5) Chief (Specify))  21. Signature of Funeral Service Funeral Ser | 7              | DU A                                     |              |   |   | v. Town or Loca                   | ation             |   | 2                                 |                      |                 | 10d. Inside City Limits |
| Corneilius Medley  Corneilius Medley  19b. Mailing Address (Street and Number or Putal Pouts Number City or Town, State, Zip Code)  Patricia Medley / Daughter 10501 Joyceton Dr. Upper Marlboro, Md.  20b. Place of Deposition  1 Burst 2 (Disposition 1 Burst 2 (Disposition 1 Burst 2 (Disposition 1 Burst 2 (Disposition 5) Chief (Specify))  21. Signature of Funeral Service Funeral Ser | Mondy          | Maryin                                   | tor          |   |   |                                   |                   | Marlboro                                  | )                                 |                      |                 | 1 XYes 2 □ No           |
| Corneilius Medley  Corneilius Medley  19b. Mailing Address (Street and Number or Putal Pouts Number City or Town, State, Zip Code)  Patricia Medley / Daughter 10501 Joyceton Dr. Upper Marlboro, Md.  20b. Place of Deposition  1 Burst 2 (Disposition 1 Burst 2 (Disposition 1 Burst 2 (Disposition 1 Burst 2 (Disposition 5) Chief (Specify))  21. Signature of Funeral Service Funeral Ser | i<br>d         | or 28e                                   | Direc        | 10e. Street and Number  |   | 71                                | 10f. Zip Code     | 20774                                     |                                   | _                    |                 | •                       |
| Corneilius Medley  Corneilius Medley  19b. Mailing Address (Street and Number or Putal Pouts Number City or Town, State, Zip Code)  Patricia Medley / Daughter 10501 Joyceton Dr. Upper Marlboro, Md.  20b. Place of Deposition  1 Burst 2 (Disposition 1 Burst 2 (Disposition 1 Burst 2 (Disposition 1 Burst 2 (Disposition 5) Chief (Specify))  21. Signature of Funeral Service Funeral Ser | 4              | 18 230<br>True                           |              |   |   | S. 13. W                          | as Decedent of    |   | Specify Yes or No                 |                      |                 |                         |
| Corneilius Medley  Corneilius Medley  19b. Mailing Address (Street and Number or Putal Pouts Number City or Town, State, Zip Code)  Patricia Medley / Daughter 10501 Joyceton Dr. Upper Marlboro, Md.  20b. Place of Deposition  1 Burst 2 (Disposition 1 Burst 2 (Disposition 1 Burst 2 (Disposition 1 Burst 2 (Disposition 5) Chief (Specify))  21. Signature of Funeral Service Funeral Ser |                | saller or item                           | y Fun        | 1 ZNever Married 2 ☐ Married  | Armed Forces?<br>1 ☐ Yes 2 ☒ No<br>If Yes, Give       | lf '                              | Yes, specify Cut  | oan, Mexican, Puer                        | to Rican, etc.)                   |                      | Black, White    | , etc.                  |
| Corneilius Medley  Corneilius Medley  19b. Mailing Address (Street and Number or Putal Pouts Number City or Town, State, Zip Code)  Patricia Medley / Daughter 10501 Joyceton Dr. Upper Marlboro, Md.  20b. Place of Deposition  1 Burst 2 (Disposition 1 Burst 2 (Disposition 1 Burst 2 (Disposition 1 Burst 2 (Disposition 5) Chief (Specify))  21. Signature of Funeral Service Funeral Ser |                | z nour                                   |              | 15. Decedent's Educ   | cation  | 16a. Decede                       | nt's Usual Occu   | pation                                    | orking                            | 16b, Kir             |                 |                         |
| Corneilius Medley  Corneilius Medley  19b. Mailing Address (Street and Number or Putal Pouts Number City or Town, State, Zip Code)  Patricia Medley / Daughter 10501 Joyceton Dr. Upper Marlboro, Md.  20b. Place of Deposition  1 Burst 2 (Disposition 1 Burst 2 (Disposition 1 Burst 2 (Disposition 1 Burst 2 (Disposition 5) Chief (Specify))  21. Signature of Funeral Service Funeral Ser | 1717           | iene.<br>r then "r                       | ompie        | Elementary/Secondary (0-12)   |   | life. DO                          |                   |   |                                   |                      | Trans           | portation               |
| Chesapeake Crematory 7-13-06   Beltsville, No.   Chesapeake Crematory 7-13-06   Chesapeake Crematory 7-   | - :            | ntei Hyg<br>ed othe<br>event,            | Be           |   | dlev  |                                   |                   |   |                                   |                      |                 |                         |
| Chesapeake Crematory 7-13-06   Beltsville, No.   Chesapeake Crematory 7-13-06   Chesapeake Crematory 7-   | , ic           | nd Me<br>mark<br>umatic                  | F            |   |   |                                   |                   |   |                                   |                      |                 |                         |
| Chesapeake Crematory 7-13-06   Beltsville, No.   Chesapeake Crematory 7-13-06   Chesapeake Crematory 7-   |                | and 2<br>eelth a<br>n 27 is              |              |   |   | _ }                               | <del>-</del>      |   |                                   |                      |                 |                         |
| 22. Name and Address of Facility Capitol Mortuary  22. Name and Address of Facility Capitol Mortuary  23. Part I Enter the disease of completations that caused the death. Short of enter the mode of dying, such as cardiac or respiratory arrest.  24. Part I Enter the disease or condition of easile on a death of easile of death of easile | 5              | ages 1<br>nt of H<br>:: if ite           |              | 1 ☐ Burial 2 💢 Cremation 3 ☐ R  |   |                                   |                   |   |                                   |                      | 4.14            |                         |
| Physician Medical Examiner  23a. Part. Emer the diseases, in complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest.  Immediate Cause (Final International Life of the Cause (Final International Life of the Cause (Final Internation |                | ortant<br>injury                         |              | 1 1   | f Ch  |                                   |                   |   |                                   |                      |                 |                         |
| Physician Medical Examiner    Page   Physician Medical Examiner   Physician   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician   Physician Medical Examiner   Physician Medical Examiner   Physician   Physician Medical Examiner   Physician Medical Examiner   | Ď              | o o i o                                  |              | Maron JM  | you fall  | ly 1.                             | 425 Ma            | ryland                                    | Ave., N                           | IE /                 |                 |                         |
| Sequentially list conditions and leading to mmediate cause. Enter Underlying cause governing of the cause o   |                |  |              |   | cations that caused the deat<br>e cause on each line. | h. 🎜o not enter                   | the mode of dy    | ing, such as cardia                       | c or respiratory a                | rrest,               |                 | Interval Between        |
| Securitally ist conditions, favouring to completion of cause of pregnancy in the past 12 months?    FEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Live birth 2   Felal death 4   Pregnant at time of death   2   Felal death 4   Pregnant at time of death   2   Felal d |                | •  |              | disease or condition  |   |                                   | MAL 11            | UFARCT                                    | 101                               |                      |                 |                         |
| Due to (or as a consequence of):    Due to (or as a consequence of):   | E              | Examiner                                 | L            | Sequentially list conditions, b   |   |                                   | ERY I             | SEATE                                     |                                   |                      |                 |                         |
| d  | 1              | ured<br>J<br>ansit                       | mine         | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conseq                                | uence ot):                        |                   |   |                                   |                      | 574             |                         |
| FFEMALE:   23b. Was deedednot pregnant in the past 12 months?   1   yes 2   No 9   Unknown   9   U   | 2              | e exection and urial-tra                 | Exa          | resulting in death) Last  | Due to (or as a conseq                                | uence of):                        |                   |   |                                   |                      |                 |                         |
| 24a. Was an autopsy performed?  PLOSTATE CANCER  25. Was case referred to medical exeminer?  1   Ves   2   No    25. Was case referred to medical exeminer?  1   Ves   2   No    26. Place of Death (Check only one)  27. Manney of Death   1   Inpatient   2   ENOutpatient   3   DOA    28. Date of Injury   28d. Describe how injury occurred    28. Place of Injury   28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how in | 700            | physic<br>s the b                        | dica         | d   |   |                                   |                   |   |                                   |                      |                 |                         |
| 24a. Was an autopsy performed?  PLOSTATE CANCER  25. Was case referred to medical exeminer?  1   Ves   2   No    25. Was case referred to medical exeminer?  1   Ves   2   No    26. Place of Death (Check only one)  27. Manney of Death   1   Inpatient   2   ENOutpatient   3   DOA    28. Date of Injury   28d. Describe how injury occurred    28. Place of Injury   28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how in | Y .            | n certit                                 | an/Me        | 23b. Was decedent pregnant  |   |                                   | ctonic pregnanc   | 74  |                                   | 2                    |                 | ,                       |
| 24a. Was an autopsy performed?  PLOSTATE CANCER  25. Was case referred to medical exeminer?  1   Ves   2   No    25. Was case referred to medical exeminer?  1   Ves   2   No    26. Place of Death (Check only one)  27. Manney of Death   1   Inpatient   2   ENOutpatient   3   DOA    28. Date of Injury   28d. Describe how injury occurred    28. Place of Injury   28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Location (Street and Number or Rural Route Number, City or Town, State)    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how injury occurred    28d. Describe how in |                | rne dear<br>y the ett<br>ached for       | ysicia       | 1 ☐ Yes 2 ☐ No  | 4☐Pregnant at time of d                               |                                   |                   | -y  | -                                 |                      | Month           | Day Year                |
| 25. Was case referred to medical exemiper?    Section of the control of the contr | L'O'           | uires thet<br>signed to<br>Id be deta    | þ            |   | tributing to death but not res                        | ulting in the und                 | derlying cause g  | iven in Part I.                           |                                   |                      |                 |                         |
| 25. Was case referred to medical exemiper?    Section of the control of the contr | 5              | aw req<br>as beer<br>2 shou              | piete        | HYPERTENSIC   | W   |                                   |                   |   |                                   |                      | 24b. Were aut   | opsy findings available |
| The state of the s |                |  | Com          | PROSTATE C  | ANCER   |                                   |                   |   | perfo                             | med?                 | death?          |                         |
| 1 Gratural   5   Pending   Injury   Mork?   1   Yes   2   No   No   No   No   No   No   No   | אַ ג <u>ַּ</u> | sicien<br>s certifi<br>irector           | 00           | exemiper?   | ospital:  | 610 utantian                      | 207 DOA 01        | her                                       |                                   |                      |                 | Z.1                     |
| 2   Accident   3   Suicide   4   Homicide   29a. Certifier   29a. Certifier   29b. Signatura and title of certifier   29b. Signatura and title of certifier   29c. License number   29c. License number   29d. Date signed (Month, Day, Year)  | 5              | ng Pny<br>ter this<br>neral c            | <del> </del> | 27. Manner of Death   | 28a. Date of Injury                                   | 28b. Time of                      |                   |   |                                   |                      |                 | ny)                     |
| 4 Homicide determined 258. Flace of injury At norm, street, factory, onice 251. Cocation (Street and Number of Paral Pouts Number).  258. Date of injury At norm, street, factory, onice 251. Cocation (Street and Number of Paral Pouts Number).  258. Date of injury At norm, street, factory, onice 251. Cocation (Street and Number of Paral Pouts Number).  258. Date of injury At norm, street, factory, onice 251. Cocation (Street and Number of Paral Pouts Number).  258. Date of injury At norm, street, factory, onice 251. Cocation (Street and Number of Paral Pouts Number).  258. Date of injury At norm, street, factory, onice 251. Cocation (Street and Number of Paral Pouts Number).  259. Cocation (Street and Number of Paral Pouts Number).  250. Cocation (Street and Number of Paral Pouts Number).  250. Cocation (Street and Number of Paral Pouts Number).  251. Cocation (Street and Number of Paral Pouts Number).  252. Cocation (Street and Number of Paral Pouts Number).  253. Cocation (Street and Number of Paral Pouts Number).  254. Cocation (Street and Number of Paral Pouts Number).  255. Cocation (Street and Number of Paral Pouts Number).  256. Cocation (Street and Number of Paral Pouts Number).  257. Cocation (Street and Number of Paral Pouts Number).  258. Cocation (Street and Number of Paral Pouts Number).  259. Cocation (Street and Number of Paral Pouts Number).  250. Cocation (Street and Number of Paral Pouts Number).  250. Cocation (Street and Number of Paral Pouts Number).  251. Cocation (Street and Number of Paral Pouts Number).  252. Cocation (Street and Number of Paral Pouts Number).  253. Cocation (Street and Number of Paral Pouts Number).  254. Cocation (Street and Number of Paral Pouts Number).  255. Cocation (Street and Number of Paral Pouts Number).  256. Cocation (Street and Number of Paral Pouts Number).  257. Cocation (Street and Number of Paral Pouts Number).  258. Cocation (Street and Number of Paral Pouts Number).  259. Cocation (Street and Number of Paral Pouts Number).  259. Cocation (Street and Num | 2              | death.<br>tor: Al                        | catic        | 2 ☐ Accident investigation  | 20a Bless of laws. At h                               |                                   | M 1               | ]Yes 2□No                                 | 286 Location (                    | Ctroot one           | ( Alumbar or Cu | ral Davida Ni           |
| 29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  | 2              | rs after<br>ei Direc<br>led in by        | Certif       | 4   Notticide   | building, etc. (Specif                                | y)<br>                            |                   |   | City or To                        | vn, State)           |                 |                         |
| 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  |                | • Hosp<br>24 hou<br>• Fune<br>letely fil | dicai        | (Check only 2 Medical Examin  | 1er: On the basis of examina                          | wledge, death<br>tion and/or inve | estigation, in my | im's, date and blac<br>opinion, death occ | and due to the urred at the time, | cause(s)<br>date and | place, and due  | state. to the cause(s)  |
|  |                | within<br>To th<br>comp                  | Me           |   | <b>→</b>  |                                   | l _               |   |                                   |                      |                 |                         |
| D40324 JULY 7,2006   |                |  | 1            |   |   |                                   |                   | 10324                                     |                                   | JUL                  | Y 7,5           | 1006                    |
| 30. Name and aldress of person who completed cause of death (Item 23a) (Type, Print)  TERRY JOS RIG MD. 7503 SURRATIS ROAD CLIWION MARKILAND 20735   |                |  |              |   |   | 5                                 | 1-45 120          | AD CLIN                                   | TON M                             | ALLY                 | LAND            | 20735                   |
| State Registrar  31. Date filed (Month, Day, Year)  32. Degistrar's Signature  |                |  |              | 31. Date filed (Month. Day, Year)   | 32. Aregistrar's Signa                                | ture And                          | 336               | ,   | -                                 |                      |                 |                         |

|                   |   |                     | 1 - For<br>State<br>Registrer   | State of Marylar  |                                       |                                     | of Health and<br>of Death  |   | giene<br>Reg. No. 20                     | 06   | 229                                  | 315                |
|-------------------|---|---------------------|---|---|---------------------------------------|-------------------------------------|--|---|--|--|--------------------------------------|--------------------|
|                   | Physici<br>/Medic<br>Examir   | al                  | 1. Decedent's Name (First, Middle, L<br>BERNAR<br>4a. Facility Name (If not institution, g<br>JOHNS HOPKIN  | ive street and number)  | N                                     |                                     | on, or Location of Dea   | 2. Date of De Month                     | Day                                      | Year<br>2006<br>of Death<br>n/a                    | 3. Time of 1                         | P M                |
|                   | Funeral<br>Director   |                     |   | Sex 7. Age (In yrs.   | last birthday)                        | If Under 1 Y                        |  |   | th<br>ay, Year)<br>26                    | 9. Birthpla<br>Countr<br>Pola                      | ace (State or<br>y)<br>and           | Foreign            |
| 36                | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28a-f ehow any njury or other traumatic event, "he Medical Exam and the modified at once.  | by Funeral Director | 10a. State 10b. County  Md 1 10e. Street and Number  245 S. Registe 11. Marital Status 1 □ Never Married 2★ Married 3 □ Widowed 4 □ Divorced  | er Street  12. Was Decedent Ever in U Armed Forces?   | J.S. 13.                              | timore<br>10f. Zip Cod              | 21231<br>of Hispanic Origin?<br>Cuban, Mexican, Pue  | (Specify Yes or No<br>arto Rican, etc.) | 10g. Citizen of US                       | What Countri<br>A<br>ce - America<br>ck, White, et | n Indian,                            | •                  |
| 21215-0036        | ed within 72 hour<br>rgiene.<br>let then "nature!<br>t, the Medical E.  | Completed t         | 15. Decedent's<br>(Specify only highest g<br>Elementary/Secondary (0-12)  | Education prade completed)  College (1-4or 5+)  | (Give                                 | DO NOT use re                       | one during most of w   | vorking                                 | 16b. Kind of B                           |  | ,                                    |                    |
| Maryland          | 2 should be fil. and Mental Hy Is marked oth Inumatic event   | To Be (             | 17. Father's Name (First, Middle, Las<br>Jacob Micial<br>19a. Informant's Name/Relationship   | K<br>(Type, Print)  |                                       |                                     | reet and Number or I   |   | er, City or Town,                        | State, Zip (                                       |                                      |                    |
| Baltimore, M      | Pages 1 and 3 lent of Health nt: If Item 27 ry or other tra   |                     | Mrs. Mary Mic:  20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spec  | ☐Removal from State   | Place of Disponentery, cre            | osition (Name of<br>matory or other | gister S<br>place) 7/<br>tory 7/   | Date                                    | 20c. Location                            | City or Tow  | n, State                             | 1                  |
| Balti             | permit. Departm Imports any nju   |                     | 21. Signature of Funeral Service Lig  | ensee Cartno  | Je 1:                                 | aczoro<br>201 Du                    | ₩skiFaFur<br>ndalk Av  | eral Ho<br>e. Balt                      | ome P.A<br>imore,                        | Md.  | 2122                                 |                    |
| 8760,             | The law requires that the death certificate be executed  X  X  X  A  State that the death certificate be executed  State that the control of | Ilcal Examiner      | 23a. Part1. Enter the disease, or so shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conseq  | quence of):                           |                                     | dying, such as cardi   |   |  | 2  | Approximate interval Betwonset and D | reen<br>leath      |
| P.O. Box 6        | es thet the death certifice<br>igned by the ettending pt<br>be detached for use as the  | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of degree of the second second second second second second second second second second second second second second second second second sec | al death 3                            | □Ectopic pregn<br>□ Other (specify  |  |   |  | te of delivery                                     |                                      | ear                |
| Records, P.       | w requires thet<br>been signed by<br>should be deta   | ۵                   | Part II. Other significant conditions   | contributing to death but not res   | sulting in the u                      | inderlying cause                    | e given in Part I.   | 23e. Did t                              | obacco use cont<br>yes 2 \( \subseteq No | ribute to the                                      |                                      |                    |
| ital Rec          | ian: The law i<br>rtificete hes bo<br>tor, page 2 sh  | Be Completed        | 25. Was case referred to medical  | OS EXPOSURI   | Ξ                                     |                                     | 26. Place of D   |   | osy<br>ormed?<br>2 D No                  | Were autops<br>prior to comp<br>death?<br>1 Yes 2  | by findings a<br>pletion of cal      | vailable<br>use of |
| Division of Vital | To the Hospital or Attending Physician: The law within 24 burus alter death.  On the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2  | ဥ                   | examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending  2 Accident investigate   | Hospital: 1 patient 2  28a. Date of Injury (Month, Day Year)  | ER/Outpatier<br>28b. Time o<br>Injury | f 28c.                              | Other  | Home 5 ☐ Resid                          | -1100                                    |  |                                      |                    |
| Divis             | ipital or Attending<br>ours after death.<br>erel Director: Attel<br>filled in by the fune   | I Certification;    | 3 Suicide 4 Homicide  6 Could not determine   |   | fy)                                   |                                     |  | City or Tov                             |  |  |                                      | ør,                |
| ,                 | To the Hospital c<br>within 24 hours af<br>to the Funeral D<br>completely filled in   | Medical             | 29b. Signature and title of certifier   | Jehner: On the basis of examina and manner stated.  | ation and/or in                       | 29c. Lic                            | re time, date and place an | curred at the time,                     | cause(s) and madate and place,           | and due to the                                     | he cause(s)<br>ay, Year)             |                    |
|                   | Sta<br>Registr  |                     | 31. Date filed (Month, Day, Year)   | o completed cause of death (Iten YEHIA M.D 32 Registrar's Signa   |                                       |                                     | TOPKINS  |   |  |  |                                      |                    |

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician July 19, Year Margaret 2006 Nelda Nathanson 10:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Edenwald Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Nov 10, 10), 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New Jersey **Funeral** 1 M 2 F 81 Yrs. 144-16-1319 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show The Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Baltimore Towson Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 800 Southerly Road 21286 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or items 11. Marital Status filed within 72 hours after 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. Specify: White 3 XWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Health init. Pages 1 and 2 should be filed within strinent of Health and Mental Hygiene. crtant: If item 27 is marked other than 'njury or other traumatic event, the Ma Elementary/Secondary (0-12) Psychiatric Nurse Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Augustus Silvernail Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol H. Dezes-P.O.A. 1608 Providence Rd,. Towson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillton Serv Corp 7/21/06 Towson, MD 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Censee William G. Dau Deportr Importa any nji 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) detached Ö the 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2) No 1 Yes 1 ☐ Yes 2 ☐ No r: After this certifica e funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 ☐ Yes 2 No Hospital: Other: ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation I Director: A 1 ☐ Yes 2 ☐ No death. 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowled e death occurred at the time date and lace and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a, Certifier and manner stated 29b. Signature and tive of certific 29c. License numbe 29d. Date signed (Month, Day, Year) more line 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink

| тапп  | et Ortman  |                 | State of Maryland / D<br>1-For State<br>Registrar   | •   | ent of Hate of D            |                           | na ivient                              | ai Hygien                        | I <b>C</b><br>Reg | No 20                    | 008         | 2291   |
|-------|--|-----------------|---|---|-----------------------------|---------------------------|--|----------------------------------|-------------------|--------------------------|-------------|--|
| Mod   | Physici  |                 | Decedent's Name (First, Middle, Last)   |   |                             |                           | ······································ | Mon                              | of Death          | Day Year                 | 3           | Time of Death                                      |
| iviea | ical Exami   | ner             | Harriet Ortman  4a. Facility Name (if not institution, give street and number)  |   | 4b (                        | City, Town, o             | or Location o                          |                                  | 13, 200           | 4c. County of            | Death       | 1150 hrs   |
|       |  |                 | 700 Washington Place, Apartment 6B  |   |                             | altimore                  |  |                                  |                   |                          | 20001       |  |
|       | Funeral<br>Director  |                 | 214-16-3256 1 M 2XF 8   | n yrs. last birt<br>35  | _                           | f Under 1 Ye<br>Months Da |  | Min.                             |                   | (MM/DD/YYYY)<br>1920     | Foreign     | olace (State or<br>tryMaryland                     |
|       | ń n  |                 | Usual Residence of Decedent         10a. State         10b. County         10c  | c. City, Town   | or Location                 | _                         |  |                                  |                   | -                        |             | 0d. Inside City Limits                             |
|       | nd<br>show s   | ř               | Maryland  | Balti   | more                        |                           |  |                                  |                   |                          |             | X Yes 2 No   |
|       | Vlaryla<br>28a-f   | Directo         | 10e. Street and Number  |   | 10                          | f. Zip Code               |  |                                  | 10g               | . Citizen of Wha         | t Country   | y?   |
|       | th the 23a or  | Ē               | 700 Washington Place, Apt 6B  |   |                             | 2120                      |  |                                  |                   | USA                      |             |  |
|       | Baltimore, MD 21215-0036  permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Deparament of Health and Mental Hygiene. Important: If time I2 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Examiner must be notified at once.   | by Funeral      | 3 X Widowed 4 Divorced If Yes, Give Year or Dates.  | If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  White, etc.  Yes 2 No specify: Specify: W. |                             |                           |  |                                  |                   |                          |             | ite  |
|       | 2 hours<br>"natur  |                 | 15. Decedent's Education (Specify only highest grade complet  Elementary/Secondary (0-12) College (1-4 or 5+)           |   | Decedent's L<br>during most |                           |  | aind of work don<br>use retired) | ie 1              | 6b. Kind of Busii        | ness/Ind    | ustry  |
|       | 036<br>thin 72<br>ne.<br>r than<br>fedical   | Completed       | 12  | Н   | omemak                      | er                        |  |                                  |                   | Own Hor                  | me          |  |
| !     | 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event. the Medica   | Be              | 17. Father's Name (First, Middle, Last) Milton Stitcher   |   |                             |                           | Myrt1                                  | s Name (First, N<br>Le B. S      | Shaw              |                          |             |  |
|       | MD 2: id 2 should lith and M in 27 is in: aumatic e  | 2               | 19a. Informant's Name/Relationship (Type, Print)  David Canby- nephew   |   |                             |                           |  | ber or Rural Ro<br>Eastor        |                   | er, City or Town,        | State, Z    | ip Code)   |
|       | e, M<br>I and 2<br>Health<br>item 2  |                 | 20a. Method of Disposition  | 20b. Place of   | of Disposition              | (Name of c                |  | Date                             |                   | 20c. Location - C        | ity or To   | wn, State  |
|       | Baltimore,  Department of Hee Important: If ite  |                 | 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee       |   | crema                       |                           | a of Facility                          | 7/26/06                          | 5                 | Catonsv:                 | ille        | , MD   |
|       |  |                 | 23a. Part I. Enter the disease, or complications that caused the  | daath Daas  | Gary                        | r L. Ka                   | aufmar                                 | 1 Funera                         | al Ho             | me at Mi<br>idge, Mi     | MP,<br>D 21 | 075  |
|       | Physician<br>/Medical  |                 | failure. List only one cause on each line.  |   |                             |                           |  |                                  | itory arrest      | , snock, or neart        |             | Approximate Interval<br>Between Onset and<br>Death |
|       | Examiner   |                 | Immediate Cause (Final disease or condition resulting in death)  Typertnerilla a mypertnerilla bue to (or as a conseque |   | ислив                       | acute (                   | ereni i                                | 112                              |                   | · ·                      | $\dashv$    |  |
|       |  | <u>.</u>        | Sequentially list conditions, if any, leading to immediate Due to (or as a conseque                                     | ance of\:   |                             |                           |  |                                  |                   |                          | -           |  |
|       |  | mine            | Cause. Enter Underlying Cause (Disease or injury that initiated c.  |   |                             |                           |  |                                  |                   |                          |             |  |
| 1     | nted<br>d<br>ansit   | Medical Examine | events resulting in death) Last  Due to (or as a conseque   | nce of):  |                             |                           |  |                                  |                   |                          | - 6         |  |
| V     | 760, icate be executed physician and the burial - transit  | lical           | XX INDENDED AMENDED   | )20 DTT   | 27 200                      | £M                        | Z -0E0 0                               | 3/7/06 TT                        |                   |                          |             | -  |
|       | 760,<br>icate b<br>iphysic<br>the bur  |                 | #F FEMALE: 23c. If yes, outcome of  |   |                             |                           |  |                                  |                   | 23d Date of de           | elivery     |  |
| ,     | Division of Vital Records, P.O. Box 687 Ist or Attending Physician: The law requires that the death certific and Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as the content of the content o | Physician.      | past 12 months?  4 Pregnant at time   | 2<br>of death 5   |                             | leath 3<br>(Specify)      | Ectopic                                | pregnancy                        |                   | Month                    | Day         | Year   |
|       | BO:<br>ne deatl<br>the att   | hysi            | 1 Yes 2 No 9 Unknown 9 Unknown  |   |                             |                           |  |                                  |                   |                          |             |  |
|       | P.O.   | by P            | Part II. Other significant conditions contributing to death but  Multiple myeloma                                       | not resulting   | g in the unde               | rlying cause              | given in Par                           | 1 236                            |                   |                          | _           | cause of death?                                    |
| į.    | dS, I<br>equires<br>een sig<br>ould be   | eted            | rattriple injerdia  |   |                             |                           |  | 24                               | a. Was an         |                          |             | sy findings available                              |
|       | e law r<br>e has b<br>ge 2 sh  | Completed       |   |   |                             | _                         |  | _                                | autopsy           | ed? dea                  | ath?        | pletion of cause of                                |
| !     | I Re   | ပိ              | 25. Was case referred to medical  |   |                             | 26 Plac                   | e of Death (                           | Check only one                   | Yes 2             | No 1                     | Yes         | 2 No   |
|       | Vita<br>hysicia<br>this ce<br>I direc  | To B            | examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient   | 2 ER/O  | utpatient 3                 | DOA                       | Other <sub>4</sub>                     | Nursing Home                     | 5 Re              | esidence 6               | Other: S    | cene   |
|       | n of Vit<br>ding Physic<br>After this of<br>funeral dire   | L:uo            | 27. Manner of Death  1 Natural 5 Page 14.   |   | Time of Injury              |                           | ury at Work?                           |                                  | escribe how       | v injury occurred        |             |  |
|       | SiOn<br>Attenc<br>r death<br>ector:<br>by the  | catio           | 2 X Accident Pending Investigation 289 Place of Injury  |   | 11:40                       |                           | Yes 2XX                                | CLIE                             | cation (Stee      | not and Number           | or Purel    | Route Number, City                                 |
|       | Divi   | Certification   | 3 Suicide 6 Could not be determined (Specify) Hou   |   | aiiii, 30 660, 16           | ctory, office             | building, etc                          | or                               | Town, Stat        | e) 700 Wash<br>timore, M | ningt       | on Place   |
|       | Division of Vital Records, P.O. Box 68760, with the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the timeral director, page 2 should be detached for use as the burial - transi   | Medical C       | 29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowness of examina                               |   |                             |                           |  | ce, and due to ti                | he cause(s        | s) and manner as         |             |  |
|       | To<br>To   | Me              | 29b Signature and title of certifier  |   |                             | 29c. Licen                | se number                              |                                  | 2                 | 9d Date signed           | (Month,     | Day, Year)   |
|       |  |                 | lahallo te  |   |                             | O.C                       | .M.E.                                  |                                  |                   | July 14, 2006            | 3           |  |
|       | Ourd   |                 | 30. Name and address of person who completed cause of death   | ,   | 11 Poss 5                   | Street De                 | timore 1                               | ID 24204                         |                   |                          |             |  |
|       | 1 1  | ate             | Zabiullah Ali, M.D. Assistant Medical Exam  31. Date filed (Martin Day) (Pear) 7 (1) 5 32. Registrar's S                | 1.0   | 11 Penn S                   | liteet, Ba                | umore, M                               | - Z 1ZU1<br>                     |                   |                          |             |  |
|       | Regis  |                 | 31. Date filed (Markin, Day) year) 7005   |   | 4                           |                           |  |                                  |                   |                          |             | :  |

|            |   | 1  | For<br>State<br>Registrar  | State  | of Marylan  |                              |                                  |            | ealth ar<br>Death                          | nd Me                   |                                  | iene<br>19. No. | nns                                       | 2              | 2912                     |  |
|------------|---|--|--|--|---|------------------------------|----------------------------------|------------|--|-------------------------|----------------------------------|-----------------|---|----------------|--------------------------|--|
|            | Dhuaisi   | ₩.   | 1. Decedent's Name (First, Midd  | le, Last)  |   |                              |                                  |            |  |                         | Date of Deat                     | Day             | Year                                      |                | ime of Death             |  |
|            | Physicia<br>/Medic  | al   | John J. Pus  |  | - <u>-</u> .  |                              |                                  |            |  |                         | July 1                           | 9, 2            | 006                                       |                | :21 P M                  |  |
|            | Examin  | er   | 4a. Facility Name (If not institution  |  |   |                              | 4b. City,                        |            | Location of I                              |                         |                                  | 4c. C           | County of Dea                             |                |                          |  |
|            | Funeral   |  | 1246 South (<br>5. Social Security Number  | 6. Sex   | 7. Age (In yrs.   | last birthday)               | If Unde                          | r 1 Year   | 1timor                                     | 4 Hrs. I 8              | . Date of Birth                  |                 | N/A                                       | thplace (      | State or Foreign         |  |
| - 4        | Director  |  | 214-44-1747  | 1 <b>X</b> M 2□ F                                | 61  | Yrs.                         | Months                           | Days       | Hours                                      | Min.                    | Month Day,                       | 194             | 5 M                                       | Maryland       |                          |  |
|            | pu »  |  | Usual Residence of Decedent  10a. State 10b. Count   |  | 10c Cit   | ty, Town or Lo               | cation                           |            |  |                         |                                  |                 |   | 10d In         | side City Limits         |  |
|            | Aaryla<br>Febor   | 5  |  | V/A  | 100. 0.1  | *                            | ltimo                            | re         |  |                         |                                  |                 |   |                | ¥Yes 2 No                |  |
|            | 28a-  | rect   | 10e. Street and Number   |  |   |                              | 10f. Zip                         | p Code     |  |                         | 1                                | 0g. Citiza      | en of What C                              | ountry?        |                          |  |
|            | 238 o   | ai D   | 1246 South Gra   | antley St  | reet  |                              |                                  | 212        | 29   |                         |                                  | Un              | ited S                                    | tate           | s                        |  |
| 036        | 172 hours after deeth with the Maryland<br>"natural", or Itema 23e or 28e-1 show<br>idical Everyl or must be rediffed at  | by Funeral Director  | 11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce   | Armed F  | 2 <b>X</b> No<br>ive  |                              | Was Dece<br>f Yes, spe<br>1  Yes |            | spanic Origir<br>n, Mexican, I<br>Specify: | in? (Specr<br>Puerto Ri | fy Yes or No-<br>can, etc.)      |                 | 4. Race - Am<br>Black, Whi<br>Specify: Wh | te, etc.       | dian,                    |  |
| 21215-0036 |   | Completed  | 15. Decede<br>(Specify only high<br>Elementary/Secondary (0-12)  | nt's Education<br>est grade completed<br>College | )<br>(1- <b>4</b> or 5+)                                      | 16a. Deced<br>(Give<br>life. | kind of wo<br>DO NOT u           | ork done d | during most o                              | of working              |                                  |                 | d of Business                             | /Industry      |                          |  |
|            | other<br>sent,  | d)   | 17. Father's Name (First, Middle   | , Last)  |   | 1                            |                                  |            |  | 's Name (i              | First, Middle, I                 |                 |   |                |                          |  |
| /lan       | should be filed within and Mental Hygiene. I marked other then umatic syent, tra M  | To B   | Joseph Walter  | pier   |   |                              |                                  |            |  |                         |                                  |                 |   |                |                          |  |
| Maryland   | ith ar<br>lith ar<br>27 is  |  | 19a. Informant's Name/Relation Carol M. Pusi   | Daug   | ghter-  | 1                            | •                                |            |  |                         | 9oute Number<br>Balti            |                 |   |                | )                        |  |
| altimore,  | Pages 1 and 2<br>nent of Heelth<br>ant: if Item 27<br>ary or other tra  | ,  | 20a Method of Disposition 1 D Burial 2 Ocremation  | 3 □Removal from                                  | State W   | Place of Disponentary, Area  | sition (Na<br>Taton e]           | me of      | θ)   | Dat                     | te                               | 20c. Loc        | ation - City o                            | r Town, S      | itate                    |  |
| Ħ          |   |  | 4 ☐ Donation 5 ☐ Other (   |  | A '   | Gremat                       |                                  | nd Addres  |  | -24-2                   | se Fun                           |                 | ton, M                                    |                |                          |  |
| Ä          | permit. Depertr importu sny inj   | 1  | Miller   | NU   | 100K  |                              |                                  |            |  |                         | , Lans                           |                 |   |                |                          |  |
|            | Physician   |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Approximately arrest, shock or heart failure. List only one cause on each line.  Onset |  |   |                              |                                  |            |  |                         |                                  |                 |   |                |                          |  |
|            | /Medical<br>Examiner  |  | resulting in death)  | Due to   | o (or as a consec<br>OBS/run                                  | quence of):                  | 87e                              | ed         | M  | ner                     |                                  |                 |   |                |                          |  |
|            | D #   | iner   | Securitizity list conditions if any, leading to immediate cause. Enter Underlying  | Due to   | (or as a consec   | quence of):                  | 1                                | 200        |  |                         |                                  |                 |   |                |                          |  |
| •          | icate be executed<br>physicien and<br>s the burial-transit  | Examin   | Cause (Disease or injury that initiated events resulting in death) Last  | c. Due to  | O (or as a consec   | quence of):                  | hesi                             | CIM        | -  |                         |                                  |                 |   |                |                          |  |
| 8760,      | e be e  | dicai E  |  | d.   |   |                              |                                  |            |  |                         |                                  |                 |   |                |                          |  |
| 9          |   | (a)  |  |  |   |                              |                                  |            |  |                         |                                  |                 |   |                |                          |  |
| P.O. Box   | The law requires that the death certific<br>ate has been signed by the attending r<br>page 2 should be detached for use as  | Physician/M  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 27€No 9 □ Unknown   | 1 🗀 Live   | utcome of pregn<br>birth 2 Feta<br>gnant at time of c<br>nown | aldeath 3                    | ∃Ectopic p<br>∃ Other (s         |            |  |                         |                                  | 2:              | 3d. Date of de<br>Month                   | olivery<br>Day | Year                     |  |
|            | uires thet the de<br>signed by the a<br>Id be detached f  | þ  | Part II. Other significant condi   | tions contributing to                            | death but not res   | sulting in the u             | nderłying                        | cause giv  | en in Part I.                              |                         | 23e. Did tol                     |                 | se contribute :                           |                | use of death? 4 □Unknown |  |
| Records,   | aw requir<br>as been si<br>2 should I   | Completed  | -> KYI   | phoscoli   | 0515  |                              |                                  |            |  |                         | 24a. Was a                       |                 | 24b. Were a                               | utopsy fi      | ndings available         |  |
| Œ.         | The<br>ate ha   | Com  |  |  |   |                              |                                  |            |  |                         | perfor                           | ned?            | death?<br>1 ☐ Ye                          | ./             |                          |  |
| Vital      | icien:<br>Sertific<br>ector,  | Be   | 25. Was case referred to medic examiner?   | Ho spital:                                       |   |                              |                                  | OA Oth     | 0.5  |                         | Check only on                    |                 |   |                |                          |  |
| of         | Phys<br>rthis<br>ral dir  | To.  | 1 Yes 2 No   | 11   | Inpatient 2   | ER/Outpatie                  |                                  | UA         | 4   14013                                  |                         | e 5 Reside                       |                 |   | ecify)         |                          |  |
| Ou         | th.<br>: Afte   | tion   | 1 Aatural 5 Pend<br>2 Accident inves   |  | onth, Day Year)   | Injury                       | м                                | Wor        | k?<br>Yes 2 □ N                            |                         |                                  |                 |   |                |                          |  |
| Division   | or Atter<br>after dea<br>Director<br>in by the  | Certification:   | 3 ☐ Suicide 6 ☐ Coul   | mined 288 Pla                                    | ce of Injury - At h<br>ding, etc. (Speci                      | nome, farm, st               | reet, facto                      | ry, office |  | 28                      | 3f. Location (Si<br>City or Town |                 | Number or F                               | Rural Rou      | ite Number,              |  |
| _          | To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 | 29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year) |  |  |   |                              |                                  |            |  |                         |                                  |                 |   | cause(s)       |                          |  |
|            | o the<br>o the<br>omple   | Mec  | 29b. Signature and title of certification  |  | or stated.  |                              | 29                               | ec. Licens | e number                                   |                         | 2                                | 9d. Date        | signed (Mor                               | nth, Day,      | Year)                    |  |
|            | - S F O   |  | Dash on-   | Draw   | Q   |                              |                                  | 004        | 7529                                       |                         |                                  | 71:             | 20/50                                     | •              |                          |  |
|            | 2   |  | 30. Name and address of person   | n who/completed ca                               | use of death (Ite   | m 23a) (Type                 | Drint)                           |            |  |                         |                                  |                 |   |                |                          |  |
| C          | <del>/</del>  |  | ANTHUM R.  | Joseph   | Pagistrar's Size  |                              | W.K                              | met        | my 8                                       | DR                      | net 1                            | M               | 2122                                      | 3              |                          |  |
| 6          | St<br>Regist  | ate<br>rar   | 31. Date filed (Month, Day, Yea  | 2006   | Registrar's Sign  | a los                        | Me.                              |            |  |                         |                                  |                 |   |                |                          |  |

|   |                     | 1 - For<br>State<br>Registrar   | State of M   | laryland / [  | Departme<br><i>Certifica</i>        |                          |   | Mental H                             | ygiene<br>Reg. No.                  | 2 11116                       | 22919   |
|---|---------------------|---|--|---|-------------------------------------|--------------------------|---|--------------------------------------|-------------------------------------|-------------------------------|---|
|   |                     | 1. Decedent's Name (First, Middle, La   | st)  |   |                                     |                          |   | 2. Date of D                         | eath<br>Day                         | Year                          | 3. Time of Death                                  |
| Physic<br>/Medi   |                     | Raymond L. Paddy  |  |   |                                     |                          |   | Tucy                                 |                                     | 200                           | 6 1.25 AM   |
| Exami   |                     | 4a. Facility Name (If not institution, giv  |  |   | 4b. Cit                             | 4 1                      | or Location of De                         | ath                                  |                                     | County of Dea                 |   |
|   |                     | Baltimere Washingt  |  |   |                                     |                          | urnie                                     |                                      |                                     | nne Ar                        |   |
| Funeral<br>Director   |                     | 5. Social Security Number 6. S 213-34-4023  | ex 7. A  | ge (In yrs. last bir<br>69                            | Yrs. Month                          | der 1 Year<br>ns Days    |   |                                      | irth<br>bay, Yea <i>r)</i><br>/1936 |                               | rthplace (State or Foreign<br>Country)<br>aryland |
| Pu .  |                     | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Tow  | n or Location                       |                          |   |                                      |                                     |                               | 10d. Inside City Limits                           |
| the Marylan r 28a-f ehow  | tor                 | MD Anne Aru   | ndel   | Glen Bu   |                                     |                          |   |                                      |                                     |                               | 1 ☐ Yes 2 ☑ No                                    |
| ith the M<br>or 28a-f   | rec                 | 10e. Street and Number  |  |   | 10f. 2                              | Zip Code                 |   |                                      | 10g. Citi                           | zen of What C                 | country?  |
| 107<br>11h wit<br>23a c   | ain                 | 106 Rippling Ridg   | e Road   |   | 21                                  | L061                     |   |                                      |                                     | USA                           |   |
| items inserting   | ner                 | 11. Marital Status  | 12. Was Decedent<br>Armed Forces                             | t Ever in U.S.  | 13. Was Dec                         | cedent of l              | Hispanic Origin?<br>ean, Mexican, Pue     | (Specify Yes or Norto Rican, etc.)   | 10-                                 | 14. Race - Am<br>Black, Wh    |   |
| 036 urs aff   | by Funeral Director | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2√☐<br>If Yes, Give Year or Dates:                   | No  |                                     | 2 <b>√</b> №             |   | ,                                    |                                     |                               | Vhite   |
| 5-0<br>72 ho  | Completed           | 15. Decedent's E<br>(Specify only highest gra   | ducation   | 16a.  | Decedent's Us                       | sual Occu                | pation                                    | orkin a                              | 16b. Kii                            | nd of Busines                 | s/Industry  |
| 12 ui a   | l du                | Elementary/Secondary (0-12)   | College (1-4or   | 5+)   |                                     |                          | during most of w                          |                                      | 1                                   |                               |   |
| CA B G F  | ပ္ပ                 | 12  |  | Park  | Mainten                             | ance S                   | Supervisor                                |                                      |                                     | l Gover                       | mment   |
| be filed that Hyge of otherward,  | Be                  | 17. Father's Name (First, Middle, Last,   |  |   |                                     |                          |   | ame (First, Middi                    | e, Maiden                           | Sumame)                       |   |
| arylan<br>should be<br>nd Mental<br>marked o  | To Be               | Charles G. Paddy  |  |   |                                     |                          | Alice I                                   | orenzo                               |                                     |                               |   |
| E SEE   | 1                   | 19a. Informant's Name/Relationship (  | Туре, Print)   | 19b   | . Mailing Addre                     | ess (Stree               | and Number or                             | Rural Route Num                      | ber, City o                         | r Town, State,                | Zip Code)   |
| and and m 27  |                     | Katherine Paddy /   | Wife   |   |                                     |                          | Ridje Ro                                  |                                      |                                     |                               |   |
| or Her  |                     | 20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐  | Bemoval from State   | cameta  | f Disposition (A<br>ry, crematory o | vame of<br>or other pla  | ce)                                       | Date                                 | 20c. Lo                             | cation - City o               | r Town, State                                     |
| Peg<br>Peg<br>Pent: I   |                     | 4 □Donation 5 □ Other (Specif   |  | Meadowri  | dge Memo                            | rial I                   | Park 07/1                                 | 3/2006                               | Elkri                               | dge, MD                       |   |
| Baltimore, Misser and 2 permit. Peges 1 and 2 Department of Heelth 2 Importent: If frem 27 is eny july or other transones.  |                     | 21. Signature of Euneral Service Licer  | 1500   |   |                                     |                          | ess of Eacility<br>an Funera<br>on Blvd., |                                      |                                     |                               | morial Park, 1                                    |
| Physician /Medical Examiner whysician and hysician and hysician and the burial-transit  | dical Examiner      | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as   | s a consequence<br>s a consequence<br>s a consequence | Mecul                               | AZ                       | Acc                                       | M<br>DENT                            |                                     |                               | Onset and Death                                   |
| Division of Vital Records, P.O. Box 68 to the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the | by Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   |  | e of pregnancy<br>2  Fetal death<br>at time of death  | 3 ⊟Ectopic<br>5 ⊡ Other (           |                          | y   |                                      | 2                                   | 23d. Date of de<br>Month      | elivery<br>Day Year                               |
| Cords, P w requires that been signed b  |                     | Part II. Other significant conditions of  | contributing to death  | but not resulting i                                   | n the underlying                    | g cause gi               | ven in Part I.                            |                                      |                                     |                               | o the cause of death?                             |
| w requirements  | ete                 |   |  |   |                                     | -                        |   | 24a. Wa                              | s an                                | 24h Were a                    | utopsy findings available                         |
| of Vital Records, Physician: The law requires to this certificate has been signe traits director, page 2 should be on   | Completed           |   |  |   |                                     |                          |   | aut                                  | opsy<br>formed?<br>2 No             | prior to<br>death?            | completion of cause of                            |
| f Vital Pysician: Thysician: The is certificate director, pag   | Be                  | 25. Was case referred to medical examiner?  |  |   |                                     | 1                        |   | eath (Check only                     | one)                                |                               |   |
| of \ Physical this call dire  | 2                   | 1 ☐ Yes 2 ☑ No  | Hospital: 1 Inpat  |   |                                     | DUA                      |   | Home 5□Re                            |                                     |                               | ecify)  |
| on of   | o                   | 27. Manner of Death 1 ■ Matural 5 □ Pending   | 28a. Dale of Inj<br>(Month, Da                               | ury 28b.<br>a <i>y Year)</i> I                        | Time of<br>njury                    | 28c. Inju                |   | 28d. Describe                        | how injur                           | y occurred                    |   |
| Attendir<br>death.<br>ctor: A<br>y the fu   | cati                | 2 Accident investigatio 3 Suicide 6 Could not b   |  |   | M                                   |                          | ]Yes 2□No                                 |                                      |                                     |                               |   |
| Division sation Attending sation death. Director: After   | Certification:      | 4 Homicide determined   | 28e. Place of in   | njury - At home, fa<br>atc. <i>(Specify)</i>          | ırm, street, fact                   | ory, office              |   | 28f. Location<br>City or To          | (Street and<br>own, State           | d Number or F<br>)            | Rural Route Number,                               |
| Divis  To the Hospital or Atti within 24 hours after de To the Funeral Directo  | edical (            | 29a Certifier 1 Certifyin Pr<br>(Check only 2 Medical Examone)  | nysician: To the besi<br>niner: On the basis<br>and manner s | of examination an                                     | death securi<br>dor investigati     | ed at the t<br>on, in my | ime, date and ele<br>opinion, death oc    | and due to the<br>curred at the time | e causa(s)<br>e, date and           | and manner :<br>place, and du | e to the cause(s)                                 |
| To th<br>withir<br>To th<br>comp  | Me                  | 29b. Signature and title of certifier   | Ser _  |   | m)                                  | 5                        | se number<br>+5149                        |                                      | ful                                 | y is                          | oth, Day, Year)                                   |
| 6   | 1                   | 30. Name and address of person who  | complet o cause of   | 1-1-00  | (Type, Print)                       | Dr.                      | se e                                      | ilen 5                               | ursi                                | re m                          | 10 21061  |
| St  | ate                 | 31. Date filed (Month, Day, Year)   | 32. Regist   | trar's Signature                                      | -1:                                 | <i>y</i> .               |   |                                      |                                     |                               |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner OREST VEN NURSING BALTIMORE LE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 12, 1923 5. Social Security Number 6. Sex 9. Birthplece (State or Foreign **Funeral** Days Mary land 1 □ M 2 ₩ F 215-12-8155 83 Yrs. Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Director MD Baltimore Catonsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 702 Edmondson Avenue 21228 USA or itams 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 0 clerical Naval Academy marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit Pages 1 and 2 should be f
Department of Health and Mental I
Important: if item 27 Is marked or Joseph Prymek Marie Smath ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Stiff/sister 8550 Parton Road #165 Granite Bay, CA 95746 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State ō Important: It any injury o '4 □Donation 5 NOther (Specify) in state 21. Signature of Funeral Service Conal u State Anatomy Board 655 W. Baltimore Street S. Wade, Director Baltimore, MD 21201 com plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or compli shock, or heart failure. List only on Approximate Interval Betwo Onset and De Immediate Cause (Final disease or condition resulting in death) estic Cardio Vascular disessi Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ending physician and use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ğ in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably page 2 should Be Completed been Carcinoma 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient No Other: 1 Tyes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending Injury To the Hospital or Attendil within 24 hours after death. To the Funeral Director: Al 1 Yes 2 No death. investigation filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Carifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and hismer as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Gartifie Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

31. Date filed (Month, Day, Year)
JUL 2 1 2006

|             |  |                  | 1 - For<br>Stete<br>Registrer   | State of              | Marylar  |                                  | artmen<br>rtificate                     |            |                              | and Me       |                                    | iene<br>g. No.   | 2006                            | 22                        | 921          |  |  |
|-------------|--|------------------|---|-----------------------|--|----------------------------------|---|------------|------------------------------|--------------|------------------------------------|--|---------------------------------|---------------------------|--------------|--|--|
|             |  |                  | Decedent's Name (First, Middle, La  | ist)                  |  |                                  |   | -          |                              | 2            | Date of Deat                       | h  |                                 | 3. Time                   | of Death     |  |  |
|             | Physic<br>/Medi  |                  | Janet S. Pertess  | ses                   |  |                                  |   |            |                              | 3            | July 16                            | , 20   | 006 Year                        | 10:2                      | 20 PM        |  |  |
| >           | Exami  |                  | 4a. Facility Name (If not institution, gire   | e street and num      | ber)   |                                  | 4b. City,                               | Town, or   | Location o                   |              |                                    | 4c. C  | County of Dea                   |                           |              |  |  |
|             |  |                  | Stella Maris Hos  |                       |  |                                  |   | ionii      |                              | Baltimore    |                                    |  |                                 |                           |              |  |  |
|             | Funeral<br>Director  |                  | 186-24-7623   | Sex 7<br>1 □ M 2 1 F  | 7. Age (In yrs.<br>7.4   | last birthday)<br>Yrs.           | If Under<br>Months                      |            | If Under a                   | Min.         |                                    | Date of Birth (Month, Day, Year)  ct 6, 1931  Pennsylvania |                                 |                           |              |  |  |
|             | and *  |                  | Usuel Residence of Decedent  10a. State 10b. County   |                       | 10c. Ci  | ty, Town or Lo                   | ocation                                 |            |                              |              |                                    |  |                                 | 10d. Inside               | City Limits  |  |  |
|             | darylan<br>f ahow  | 5                | MD Baltimo  | re                    |  |                                  | imore                                   |            |                              |              |                                    |  | es 2√√ No                       |                           |              |  |  |
|             | the 1  | rect             | 10e. Street and Number  |                       |  | Dare                             | 10f. Zip                                |            |                              |              | 1                                  | 0g. Citiz  | en of What Co                   | <b></b>                   | <u> </u>     |  |  |
|             | 3a or  | Funeral Director | 9279 C Throgmort  | on Road               |  |                                  |   | 212        | 34                           |              |                                    | U  | SA                              |                           |              |  |  |
|             | deeth  | nera             | 11. Marital Status  | 12. Was Deced         |  |                                  | Was Deced                               | ient of H  | ispanic Orig                 | gin? (Specif | fy Yes or No-                      | 1-   | 4. Race - Ame                   |                           |              |  |  |
| 9           | after<br>or its  | F                | 1 ☐ Never Married 2 ☐ Married   | 1 Tes 2               | 2 X No   |                                  | If Yes, spec<br>1 ☐ Yes 2               |            | Specify:                     | , rueito rik | can, etc.)                         |  | Black, Whit                     |                           |              |  |  |
| 93          | ural'.   | d by             | 3 ☐ Widowed 4 🙀 Divorced  | Year or Da            | tes:   |                                  |   |            | <i>Open,</i>                 |              |                                    |  | Specify:                        | white                     | 1            |  |  |
| 21215-0036  | within 72 hours after deeth with the Maryland<br>ene.<br>than "natural", or items 23e or 28e-f ahow<br>ha Mudicel Evardi.et must be mutified at  | Completed        | 15. Decedent's E<br>(Specify only highest gr  |                       |  | (Give                            | dent's Usua<br>kind of wor<br>DO NOT us | rk done d  | durina most                  | of working   |                                    | 16b. Kin   | d of Business                   | /Industry                 | unk          |  |  |
| 12          | withir<br>ene.<br>then   | dmo              | Elementary/Secondary (0-12)   | College (1-           | 4or 5+)  | /// O.                           |   |            | work                         |              |                                    |  |                                 |                           |              |  |  |
| 9           | filed<br>Hygi<br>other   |                  | 17. Father's Name (First, Middle, Las.  |                       |  | J                                |   |            |                              | r's Name (/  | First, Middle, I                   | Maiden S   | Битате)                         |                           |              |  |  |
| an          | lid be<br>lental<br>ked c  | To Be            | Lyman Leceiste  | r Statle              | r  |                                  |   |            | Mac                          | dalene       | e Ester                            | Wa]  |                                 |                           |              |  |  |
| Maryland    | 12 should be filed within hand Mental Hygiene. 7 is marked other than "riraumatic avent, the Medical Control of th | -                | 19a. Informant's Name/Relationship  | (Type, Print)         |  |                                  |   |            |                              |              | Route Number                       |  |                                 | Zip Code)                 |              |  |  |
|             | and 2<br>saith a<br>n 27 is  |                  | Preston Pertess   | es/son                |  | 5601                             | Selfo                                   | ord l      | Road I                       | Haleth       | norpe,                             | MD 2   | 21227                           |                           |              |  |  |
| Baltimore,  | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or itame 23e or 28e-1 show amportant: if item 27 is marked other then "natural", or itame 29e or 28e-1 show any hipty or other traumatic event, the Medical Evernitar must be notified at 2002.   |                  | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [ 4 🖾 Donation 5 ☐ Other (Speci   |                       |  | Place of Dispo<br>cemetery, crea |   |            | e)                           | Dat          | е :                                | 20c. Loc   | ation - City or                 | ty or Town, State         |              |  |  |
| Balti       | permit. Depertm Importa any Inju   |                  | 21. Signature of Funeral Service Licensee  Ronald S. Wade Director  State Anatomy Board 655 W. Baltimore  Baltimore, MD 21201  23a. Part. Solver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |                       |  |                                  |   |            |                              |              |                                    |  |                                 |                           | :            |  |  |
| 8760,       | Physician and buyascian and buyascian and stand stand stand stand stands.  | dicai Examiner   | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b                     | CELL  of as a consecutive as a consecuti | quence of):<br>quence of):       | ANCER                                   |            |                              |              |                                    |  |                                 | Onset an                  | d Death      |  |  |
| P.O. Box 68 | ne death certifi<br>the attending<br>thed for use as   | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown   |                       | th 2 Feta<br>nt at time of c   | al death 3                       | Ectopic pro                             |            |                              |              |                                    | 23   | 3d. Date of del<br>Month        | livery<br>Day             | Year         |  |  |
| Records, P. | uires that the signed by Id be detact  | by               | Part II. Other significant conditions   | contributing to dea   | ath but not res  | ulting in the u                  | nderlying ca                            | ause give  | en in Part I.                |              |                                    |  | e contribute to                 |                           |              |  |  |
| S           | w requir<br>been si<br>should  | Completed        |   |                       |  |                                  |   |            |                              |              | 24a. Was a                         |  | 24b. Were at                    | utonsy finding            | ne available |  |  |
| Re          | The lav  | mc<br>duc        |   |                       |  |                                  |   |            |                              |              | autops<br>perforn                  | y<br>ned?  | prior to death?                 | completion of             | cause of     |  |  |
| a           |  | CO               | 25. Was case referred to medical  |                       | -  |                                  |   |            | OC Disease                   | of Dooth //  | 1 Yes 2                            |  | 1 ∐ Yes                         | 2 □ No                    |              |  |  |
| of Vital    | Physician:<br>this certific<br>ral director,   | To B             | examiner?<br>1 ☐ Yes 2 ☑ No   | Hospital:             | patient 2  | ER/Outpatier                     | nt 3∏ DO                                | A Othe     |                              |              | Check only on<br>5 ☐ Reside        |  | YOther (Soe                     | POH (vite)                | PTCF         |  |  |
| 10          | g Phys<br>er this<br>iaral dii   |                  | 27. Manner of Death   | 28a. Date of          |  | 28b. Time o                      |   | 8c. Injun  |                              |              | d. Describe ho                     |  |                                 | city) HOD                 | LICE         |  |  |
| io          | Attanding<br>ir death.<br>ector: After<br>by the funa  | atio             | 1 XNatural 5 ☐ Pending 2 ☐ Accident investigated  |                       | , Day (Gal)  | Injury                           | м                                       |            | Yes 2 1                      | No           |                                    |  |                                 |                           |              |  |  |
| Division    | al or Atta<br>s after des<br>il Directo<br>id in by th   | Certification;   | 3 ☐ Suicide 6 ☐ Could not to determined   | 286. Place            | of Injury - At h<br>g, etc. (Special   | ome, farm, str                   | reet, factory                           | , office   |                              | 281          | Location (St.<br>City or Town      |  | Number or Ru                    | ural Route No             | umber,       |  |  |
|             | To the Hospitel or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral  | Medical C        | 29a. Certifier 17 Certifying P (Check only one) 2 Medical Exe   | hysician: To the base | sis of examina   | owledge, deat<br>ation and/or in | h occurred a<br>vestigation,            | at the tim | ne, date and<br>pinion, deat | d place, and | d due to the ca<br>at the time, da | use(s) a<br>ite and p                                      | and manner as<br>place, and due | s stated.<br>to the cause | 9(s)         |  |  |
|             | withii To th   | Ž                | 29b. Signature and title of sertifier   |                       |  |                                  | 29c                                     | -          | number                       |              | 2                                  | d. Date  | signed (Mont                    | h, Day, Year,             | )            |  |  |
|             |  |                  | /   |                       |  |                                  |   | リト         | 377                          | 25           |                                    |  | 7/17/0                          | 06                        |              |  |  |
|             |  |                  | 30. Name and address of person who  | completed cause       | of death (Iter   | m 23a) (Type,                    | Print)                                  |            | ·                            |              |                                    |  | 1.1                             |                           |              |  |  |
|             |  |                  | DR. TARIQ MAHMOO  |                       |  | Y VALL                           | EY RD                                   | . T        | IMONI                        | UM, M        | D 2109                             | 3  |                                 |                           |              |  |  |
|             | St:<br>Regist  | ate              | 31. Date filed (Month, Day, Year)   |                       | gistrar's Signa  | ature                            | . M. c                                  |            |                              |              |                                    |  |                                 |                           |              |  |  |

JULY 16, 2006 10:20 a.m.

JANET PERTESSES

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician **PARKS** JULY 2:30 A.M HARRIET 20, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS HOSPICE TIMONIUM BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-06-1930 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours 1 □ M 2 X F 213-30-3971 76 Yrs. MARYLAND Director Usual Residence of Decedent with the Maryland or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. BALTIMORE 1 Yes 2XXNo TIMONIUM Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ith and Mental Hygiene. 27 is marked other then "natural", or items 23s or traumatic event, the Medical Exercit at musike. 2300 DULANEY VALLEY ROAD 21093 U. S. A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Yes ON No 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed X X Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REAL **ESTATE** REAL ESTATE AGENT Year 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **FENTON** GLEN AUDREY STEUART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2...
Depertment of Health at Importent: If Item 27 is eny injury or other traugons. CYNTHIA L.WEISMAN (DAUGHTER) 3028 SHEPPERD ROAD, MONKTON, MARYLAND, 21111 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State HILLTOP SERVICE CORPL 07-21-2006 TOWSON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD (R.G.RUTH) RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 K. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stage **Physician** /Medical Due to (or as a consequence of): Examiner 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires thet the death certificate be executed ettending physicien end for use as the burial-transit Due to (or as a consequence of): vision of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was ... autopsy performed? Yes 21 No this certificete hes al director, pege 2 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours el To the Funerel D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2300 Dulaney Valley RD. Timonium, MD 21093 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 12:30 AMM Robert R. Ruby July 20, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex, 1X M 2 F Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 76 Director 212-26-5997 12/03/1929 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8562 Harris Avenue 21234 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after al Hygiene. other than "naturel", or ite 1 Never Married 2 Married 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: ፩ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) Carpenter 10 permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth any linjury or other traumatic event sing. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Grayson Ruby Marie Youdel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Ruby/Wife 8562 Harris Avenue Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jul 21 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licensee 22 Name and Address of Facility & Kuli Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final MCAA and Nelle Cauce) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and thed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 Yes 2 No 1 Yes 2 № No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified rector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) \ \( \alpha \) \( \alpha \) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 058303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harles St British and 21204 CHANGES, WD 6601 N. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 2 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1, perMD 8857,7/21/06 TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nellie Pauline Rainier Raynor **Physician** 2006 10:16 AM JULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) July 11, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months 1 ☐ M 2 🛣 F 77 215 22 2146 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits orthen "naturel", or iteme 23a or 28e-f ehow Maryland 1 Yes 2 No Directo Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 21225 5214 Brookwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 →Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) Private duty care provider Self employed 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi and Mental H is marked of Pauline Alice Davis James Horace Parks ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Heelth an item 27 is 1 Brenda Joy Fowler / daughter 235 Green Street Centreville, Maryland 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If its any injury or ot 1 Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 7/24/2006 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 mamerou 23a. Part1. Enter the diseas. At implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ptic Shock disease or condition resulting in death) dry /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the 23c. ff yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1XYes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

Librilla Yes 25 No obstructive 1 ☐ Yes atrial 28 No To the Hoepital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient ပ္ 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Oate of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Coufd not be 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD, FCCP D 36845 July 20, 2006 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) Mai-Chi Waryen, Unive grace Colum 500 31. Date filed (Month, Day, Year) strar's Signature State Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** -ornelius 2350 M 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner M Cdical Baltimore Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) MY 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min Months Days Hours 1 M 2 F Yrs Director 101e 29,2004 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo 10e. Street and Number 10g. Citizen of What Country? "naturel", or iteme 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ NO Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. If item 27 is marked other than "naturel", or itement illy or other traumath. Black, White, etc. 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Yes, Give 'ear or Dates: Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ultant 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marcella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marce aliquete Avenue (tinorem) ZIZOW 20b. Place of Disposition (Name of Date 20a. Method of Disposition Bunal 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 9 29 2006 PAUTIMORE Attlebral 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Z134 Willowspring ASYLON F.H.P.A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): P.O. Box 68760, the attending physicien Physician/Medicai for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 1 No 1 🗆 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 Yes Hospital: Other: 4 Nursing Home 2 1 No 2 1 Impatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 1 Matural 5 ☐ Pending investigation 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year)

Registrar DHMH 17 Rev 1/2001

State

Registrar's Signature

30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕕 🕕 🦒 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Tary 8:37AM 18 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mary and Medical Center
6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 2 F Months Director 59 220-42-2832 October 8, 1946 Maryland Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Mcdical Examinar must be notified at 1 ☐ Yes 2 No Director Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 3825 Graceland Ct. U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: Specify: If Yes, Give Year or Dates: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Postal Service Elementary/Secondary (0-12) College (1-4or 5+) R.E. Representitive 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence Elizabeth Feller Francis Melvin Rover ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is eny injury or other traconce. 3825 Graceland Ct. Ellicott City, Maryland 21042 Mr. Calvin Richardson Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 07/22/2006 Brentwood, Maryland 4 ☐Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 22. Name and Address of Facility Slack Funeral Home, P.A. 23a. Part1. Enter the dis as of complications that your of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 4 months Non Small cell lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien end for use as the burial-translt Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death signed by the ail 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown peeu: 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 No 25. Was case referred to medicaf examiner? Certification: To Be 26. Place of Death (Check only one, Hospital: Other: 1 Yes 2 THO 1 Thipatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this completely filled in by the funeral 27. Mannes of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 @Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide after within 24 hours a 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Richard

31. Date filed (Month, Day, Year)

Ericson

2

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Green

South

32. Registrar's Signature

Street; Baltimore, MD 21201

|                     |   |                | For State Registrar   | ot Marylan  |  | artment of F<br>rtificate of I                             | lealth and M<br>Death                                  |  | iene 0 0 6                                   | 22921  |
|---------------------|---|----------------|---|---|--|--|--|--|--|--|
|                     |   |                | Decedent's Name (First, Middle, Last)   |   |  |  |  | 2. Date of Deat                                  | h  | 3. Time of Death                                   |
|                     | Physicia<br>/Medic  |                | Patricia Ann Schmitz  |   |  |  |  | July 19,   | 2006 Year                                    | 10:50 ам   |
| 1                   | Examin  |                | 4a. Facility Name (If not institution, give street and  | number)   |  |  | Location of Death                                      |  | 4c. County of De<br>Harfo                    |  |
|                     |   |                | 227 E. Belcrest Road  5. Social Security Number 6. Sex  | 7 400 //0 110   | lo at histhele . 1   | Bel A  | If Under 24 Hrs.                                       | O Date of Birth                                  |  |  |
|                     | Funeral<br>Director   |                | 578-46-3978  Usual Residence of Decedent  | 7. Age (In yrs. 73  | Yrs.   | Months Days  | Hours Min.   | 8. Date of Birth<br>(Month, Day,<br>June 25,     | Year) 9. 80<br>1933 Ma                       | nthplace (State or Foreign<br>country)<br>ryland   |
|                     | /land   |                | 10a. State 10b. County  | 10c. City   | y, Town or Lo  | cation   |  |  |  | 10d. Inside City Limits                            |
|                     | Man,<br>Be-1 sh   | tor            | Md. Harford   |   |  | Bel Ai   | r  |  |  | 1 ☐ Yes 2€ No                                      |
|                     | th the  | Director       | 10e. Street and Number  |   |  | 10f. Zip Code  |  | 10   | 0g. Citizen of What C                        | ountry?  |
|                     | ath w   |                | 227 E. Belcrest Road  |   |  |  | 014  |  | U.S.A.                                       |  |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. | by Funeral     | 1 Never Married 2 Married 1 Yes,  | ecedent Ever in U.<br>Forces?<br>s 2 No<br>Give<br>r Dates:             |  | Was Decedent of H<br>f Yes, specify Cuba<br>1 ☐ Yes 2 1 No | ispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)                 | 14. Race - Arr<br>Black, Wh<br>Specify: W    | ite, etc.  |
| 2-0                 | 72 ho<br>natur<br>iical   | Completed      | 15. Decedent's Education (Specify only highest grade complete   | d)  | 16a. Dece  | tent's Usual Occup   | ation<br>during most of work                           | ina  | 16b. Kind of Busines                         | s/industry   |
| 2                   | vithin<br>ne.<br>han *  | mpi            | Elementary/Secondary (0-12) College   | 9   | L  |  |  |  |  |  |
| 2                   | filed v<br>Hygie<br>other t   |                | 17. Father's Name (First, Middle, Last)   | ministrat  18. Mother's Name  |  | l<br>vernment  |  |  |  |  |
| ä                   | id be<br>ental<br>ked o<br>ic eve   | To Be          | Dr. Frederick O. Hodou  | S   |  |  | Elizabet   |  |  |  |
| ary                 | should Ind Men  |                | 19a. Informant's Name/Relationship (Type, Print)  |   | City or Town, State,   | Zip Code)  |  |  |  |  |
|                     | and 2<br>ealth ar<br>n 27 is  |                | Dr. Frederick L. Hodou  | s/brother   | 306  | Patterso   | n Mill Ro  | ad, Bel  | Air, Md.                                     | 21015  |
| Baltimore,          | of He   |                | 20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3 □ Removal fro   |   | lace of Dispo<br>emetery, crea   | sition (Name of<br>natory or other place                   | (8:  | Date 2   | 20c. Location - City o                       | r Town, State                                      |
| Ĕ                   | Pages tment of I tant: If its   |                | ' 4 ☐ Donation 5 ☐ Other (Specify)  |   |  | Crematory  |  |  | Baltimore,                                   |  |
| Ba                  | permit. Departnimports any inju   |                | 21. Signature of Funeral Service Licensee   |   | Bel Air,   |  |  |  |  |  |
|                     |   |                | 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of         | at caused the death   |  |  | /  |  |  | Interval Retween                                   |
| ç                   | Physician   |                | Immediate Cause (Final disease or condition resulting in death)   | ETASTI  | e c  | SVAV-IA  | N CARO   | INOM   | †  | Onset and Death                                    |
| ı                   | /Medical<br>Examiner  |                | Due Due   | to (or as a consequ   | uence of):   |  |  |  |  |  |
|                     |   | e              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | to (or as a consequ   | uence of):   |  |  |  |  |  |
|                     | cuted   | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events                                      |   |  |  |  |  |  |  |
| Ö,                  | tificate be executed<br>ig physician and<br>as the burial-transit   | Exe            |   | to (or as a consequ   | uence of):   |  |  |  |  |  |
| 68760,              | ate be  | edicai         | d   |   |  |  |  |  |  |  |
|                     |   |                | IF FEMALE: 230 If year  | outcome of progre   |  | <u></u>  |  |  |  |  |
| P.O. Box            | The law requires that the death centate has been signed by the attendin page 2 should be detached for use   | Physician/N    | in the past 12 months?  | outcome of pregna<br>e birth 2 ∏ Fetal<br>egnant at time of do<br>known | death 3  | Ectopic pregnancy Other (specify)                          |  |  | 23d. Date of de<br>Month                     | Day Year   |
| ٦,                  | s that<br>pned b  | by Pł          | Part II. Dther significant conditions contributing to   | death but not resu  | ulting in the u  | nderlying cause give                                       | en in Part I.  | 23e. Did tob                                     | acco use contribute                          | to the cause of death?                             |
| ğ                   | w requires t<br>been signe<br>should be   |                |   |   |  |  |  | 1 □ Ye   | s 2 No 3 F                                   | Probably 4 Onknown                                 |
| Records,            | The law rate has be   | Completed      |   |   |  |  |  | 24a. Was ar<br>autops<br>perform<br>1 \sum Yes 2 | prior to death?                              | utopsy findings available completion of cause of s |
| Vita                |   | Bec            | 25. Was case referred to medical examiner?  |   |  |  | 26. Place of Deatl                                     |  |  | 3 20110  |
|                     | Physic<br>this co   | ို             | 1 ☐ Yes 2 ☐ No Hospital: 1  |   | ER/Outpatier   |  | 4   Nursing Ho   |  | nce 6 Other (Sp.                             | ecify)   |
| Division of         | Jing F  | ion            | 1 ☑ Natural 5 ☐ Pending (M  | te of Injury<br>onth, Day Year)   | 28b. Time of<br>Injury   | Wor  | /at<br>k?<br>Yes 2 □No                                 | 28d. Describe ho                                 | w injury occurred                            |  |
| /ISI                | Attending Physician: or death. ector: After this certifica by the funeral director, I   | fical          | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pla                                       | ace of Injury - At ho   | ome, farm, str   |  |  | 28f. Location (Str                               | eet and Number or F                          | Rural Route Number                                 |
| 2                   | al or /<br>s after<br>N Dire  | Certification: | 4 Homicide  | ilding, etc. (Specif)   | 1)   | ,,,  |  | City or Town                                     | , State)                                     |  |
|                     | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,  | Medical (      | 29a. Certifier (Check only one)  1 Certifying Physician: To 2 Medical Examiner: On the and m                | the best of my kno<br>basis of examina<br>anner stated.                 | wledge, death<br>tion and/or in  | n occurred at the tin<br>vestigation, in my o              | ne, date and place,<br>pinion, death occurr            | and due to the ca<br>red at the time, da         | use(s) and manner a<br>ite and place, and du | s stated.<br>e to the cause(s)                     |
|                     | To the within 2 To the complet  | Me             | 29b. Signature and title of certifier   | (   | 1.1  | 29c. License   | e number   | _ 29   | d. Date signed (Mor                          | th, Day, Year)                                     |
| )                   | 1   |                | Hound will  | nor b   | The state of the s | 0  | 31775  | V  | uly. 20.                                     | 2006   |
|                     | 5   |                | 30. Name and address of person who completed c  | ause of death Vitem   | 23a) (Type,  | Print) 21/2<br>AUSTON                                      | MAR  | ROAN   | 0 2109                                       | 47   |
|                     | Sta<br>Registr  | _              | 31. Date filed (Month, Day, Year) JUL 2 1 2006  | Registrar's Signa   | The for  | who .  |  |  |  |  |

|                                |   | ,              | 1 _ State  | State of Maryla   |                                     |   | of Health and I<br>of Death                         |   | ZUUt                                   | 22928  |  |
|--------------------------------|---|----------------|--|---|-------------------------------------|---|---|---|--|--|--|
|                                | Physicia  | an             | Registrar     Decedent's Name (First, Middle, Last)  | MARY E. S   |                                     |   | Or Bouil  | 2. Date of Death<br>Month                         | Day Year                               | 3. Time of Death   |  |
|                                | /Medic<br>Examin  |                | 4a. Facility Name (If not institution, give str  |   | 7011711 7 21                        |   | wn, or Location of Death                            | n acy   | 4c. County of Death                    |  |  |
|                                | Funeral<br>Director   |                | 5. Social Security Number 6. Sex 1 Number 1 Number 6. Sex 1 Number |   | Center<br>s. last birthday)<br>Yrs. |   | Burnie<br>Year If Under 24 Hrs.<br>Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Y                | ear) 9. B                              | intelel<br>intellige (State or Foreign<br>Country)<br>laryland |  |
|                                | ehow  |                | 10a. State 10b. County   | 10c. C  | City, Town or Lo                    | ocation   |   |   |  | 10d. Inside City Limits  |  |
|                                | the Mar<br>28e-f et   | Director       | Maryland Anne Arum   | ndel  |                                     | F.  | inthicum  |   |  | 1 ☐ Yes 2√ No  |  |
| $\rightarrow$                  | with th   | Dire           | 10e. Street and Number   | wood Road   |                                     | 10f. Zip Ci                                     | 21090   | 10g   | . Citizen of What (<br>USA             | Country?   |  |
| 2                              | er death w<br>Items 23s   | Funerai        |  | 2. Was Decedent Ever in   | U.S. 13.                            | Was Deceder                                     | nt of Hispanic Origin? (S<br>Cuban, Mexican, Puert  | pecify Yes or No-                                 | 14. Race - An                          | nencan Indian,   |  |
| Z 98                           | urs aft   | by             | 1 ☐ Never Married 2 ☐ Married<br>3 【 Widowed 4 ☐ Divorced  | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:                                      |                                     | 1 Tes, specify                                  |   | o Hican, etc.)                                    | Black, Wi                              | White  |  |
| (e)<br>15-(                    | n 72 h<br>"natu<br>edica  | iete           | 15. Decedent's Educa<br>(Specify only highest grade of   | completed)  | (Give                               | dent's Usual (<br>kind of work of<br>DO NOT use | done during most of wor                             | rking 16  | b. Kind of Busines                     | s/Industry   |  |
| chaffeld,<br>aryland 21215-00; |   | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5+)  |                                     | elephon   | · .   | •   | C&P Tel                                | ephone Co.   |  |
| A f                            | be filed<br>ital Hygi<br>id other<br>event, I   | Be             | 17. Father's Name (First, Middle, Last)  |   |                                     |   |   | ne (First, Middle, Ma                             |  |  |  |
| - Z                            | should<br>nd Men<br>marke   | မ              | Edward Jone 19a. Informant's Name/Relationship (Type   |   | 19b. Maili                          | na Address /S                                   | EI12<br>Street and Number or Ru                     | cabeth So   |  | Zin Code)  |  |
|                                | end 2 salth an n 27 ie.   |                | John M. Schaffeld  | (Son),  |                                     | 5=17760)  | ood Rd., L  |   | me mean                                | 22   |  |
| Baltimore,                     | of Heron<br>of Heron<br>of tem  |                | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei   | mayal from State  | Place of Dispo<br>cemetery, crei    | osition (Name<br>matory or othe                 | of<br>er place)                                     | Date 20   | c. Location - City                     | or Town, State   |  |
| ţ                              | t. Pag<br>rtment<br>rtant: I  |                | 4 Donation 5 Other (Specify)  21. Signature of Furjeral Service Licensee   | G1  | en Have                             |   |   |   |  | e, Maryland  |  |
| Bal                            | Depa<br>Impo<br>any ir  |                | 21. Signature of Funeral Service Licensee  | · Kevin E Ec<br>———   | ker 2                               | IcCullly  | Address of Facility<br>Y-Polyniak I<br>Patapsco Av  | Funeral Ho  | me, P.A.                               | 21225-1856   |  |
|                                |   |                | 23a. Part1. Enter the disease, or complications, or heart failure. List only one   | ations that caused the de   | ath. Do not en                      | ter the mode of                                 | of dying, such as cardiac                           | or respiratory arres                              | i.                                     | Approximate<br>Interval Between                                |  |
|                                | Physician   |                | Immediate Cause (Final disease or condition  | Anoxic  | Ence                                | phal  | opathy.   |   |  | Onset and Death  |  |
|                                | /Medical<br>Examiner  |                | resulting in death)  | Due to (or as a conse   | equence of):                        |   |   |   |  |  |  |
| ,                              | 100   | Jer            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Des to (or as a cons  | equenes of):                        |   |   |   |  | 1  |  |
| V                              | ate be executed hysicien and the burial-transit   | Examiner       | Cause (Disease or injury that initiated events c. resulting in death) Last   | D. 10 (22 22 22 22 22 22 22 22 22 22 22 22 22   |                                     |   |   |   |  |  |  |
| 8760,                          | be ex<br>sicien<br>burial   |                |  | Due to (or as a conse   | equence or):                        |   |   |   |  |  |  |
| 9                              | ifficate<br>g physias the   | ledical        | d.   |   |                                     |   |   |   |  |  |  |
| Vital Records, P.O. Box        | Attending Physicien: The law requires that the death certific death. sctor: After this certificate has been signed by the attending py the funeral director, page 2 should be detached for use as | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  | c. If yes, outcome of preg<br>1 □ Live birth 2 □ Fe<br>4 □ Pregnant at time of<br>9 □ Unknown | tal death 3                         | ⊒Ectopic preg<br>⊒ Other (s <i>pec</i>          |   |   | 23d. Date of d<br>Month                | lelivery<br>Day Year   |  |
| o.                             | es thet the lgned by be detact  | by Ph          | Part II. Other significent conditions conti  | ributing to death but not re  | esulting in the u                   | inderlying cau                                  | se given in Part I.                                 | 23e. Did toba                                     | cco use contribute                     | to the cause of death?   |  |
| ords                           | w require<br>been slg<br>should b   | ted b          |  |   |                                     |   |   | 1 □ Yes   | 2 □ No 3 □                             | Probably 4 Dunknown  |  |
| ec.                            | hes be  | Completed      |  |   |                                     |   |   | 24a. Was an<br>autopsy<br>performe                | 24b. Were prior to                     | autopsy findings available o completion of cause of            |  |
| Tal F                          | in: Th<br>ificete<br>or, pag  | e Co           | 25. Was case referred to medical   |   |                                     | · · · · · · · · · · · · · · · · · · ·           | 00 Plans # Paul                                     | 1 ☐ Yes 2 【                                       | 1 Y                                    | es 2 <sup>th</sup> No  |  |
|                                | ysicia<br>is cert<br>directo  | To B           | avaminar?  | ospital:  | ☐ ER/Outpatie                       | nt 3□ DOA                                       | Other   | ath <i>(Check only one)</i><br>forme 5 ☐ Resident | ce 6 □Other (Si                        | pecify)  |  |
| jo c                           | ng Ph<br>ster th<br>neral   | L:io           | 27. Mannar of Death  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time o                         |   | : Injury at<br>Work?                                | 28d. Describe how                                 |  |  |  |
| Division                       | To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this cardificate he completely filled in by the funeral director, page                  | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury - At<br>building, etc. (Spe  | home, farm, st                      | meet, factory, o                                | 1 Yes 2 No  | 28f. Location (Stre<br>City or Town,              | et and Number or<br>State)             | Rural Route Number,  |  |
|                                | ne Hospita<br>24 hours<br>ne Funerel<br>detely fillec   | Medical C      | 29a. Certifier 1 Certifying Physic (Check only one)  | ician: To the best of my ker: On the basis of exami<br>and manner stated.                     | nowledge, deat<br>nation and/or in  | th occurred at<br>nvestigation, in              | the time, date and place<br>may opinion, death occu | a, and due to the cau<br>urred at the time, date  | se(s) and manner<br>a and place, and d | as stated.<br>ue to the cause(s)                               |  |
|                                | To the within To the comp   | M              | 29b. Signature and title of certifier  2004  30. Name and address of person who com  | With  | M                                   | 29c. 1  | License number 41365                                | 290   | Date signed (Mo                        | nth, Day, Year)<br>2006  |  |
| _                              | 10  |                | 30. Name and address of person who com   |   |                                     | Print) HOSP                                     | tal Drive   | , Glen ?  | Burnie,                                | MD, 21061  |  |
|                                | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year)  JUL 2, 1 2006   | 32. Registrar's Sig   | gnature                             | ٠. هم   |   |   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U State Amend item#7,18, perFH, C858, 8/22/06 Tertificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 7:04 PM 2006 Jaren /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Play Year North) | North (Month, Play Year August 3, 7. Age (In yrs. last birthday) Johns 5. Social Security Number 1<u>950</u> Birthplace (State or Foreign
Country) **Funeral** 1 ■ M 2 F 55 220-54-8443 Director Australia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1627 Belt Street 21230 U.S.A. 238 Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 11ed within 72 hours after 1 Never Married 2 Married "neturel", or 1 ☐ Yes 2 I No Specify: White Baltimore, Maryland 21215-0036 þ Specify 3 ☐ Widowed 4 Ø Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Concierge Mercy Ridge 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be <del>Wattington</del> Waddington James Kuhne The1ma ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 111 Spencer Terrace S.E. Peter A. Stewart (Son) Leesburg, Virginia 20175 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ō <u>=</u> 1 ☐ Burial 2 Ø Cremation 3 ☐ Removal from State permit. Page Department Importent: It any injury o Bayview Crematory 07-21-06 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility MgGullyFPolyRiakuFungraliHome,PMaryland 21230 232 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 13 Zu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinentiate cause. Enter Underlying Cause (Disease or injury that initiated events سكو Due to (u. as a consequence of) Physician/Medical Examine The law requires that the death certificate be executed attending physicien and for use as tha burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknow been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 X No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an paga 2 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death | Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Sath te of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation nours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) ş 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000 mp July 16 2006 30. Name a, d address of person who completed cause of death (Item 23a) (Type, Print) 600 North Write Street Bultimore MD 01187 31. Date filed (Month, Day, Year) 32: Registrar's Signature State JUL 2 1 2006 Registrar DHIVIH 17 Hay 1/2001

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

|  |                | 1- For State Registrar Amen  | d #1                      | Per Me G                          | 357 7                | / <b>£</b> 12/10 | ij (caija   | Hof .    | Death                                |               |               |                     | Reg. No   | 21                              | UU                           | 6 2293                                    |
|--|----------------|--|---------------------------|-----------------------------------|----------------------|------------------|-------------|----------|--------------------------------------|---------------|---------------|---------------------|-----------|---------------------------------|------------------------------|---|
| Physici<br>dical Exami   | an/            | 1. Decedent's Name   | (First, Migg              | Edv                               | ward                 | Wati             | ts S        | ome      | rville                               |               | 2             | Date of De<br>Month | Day       | Year                            | r                            | 3. Time of Death<br>1810 hrs              |
| una,   |                | 4a. Facility Name (if  | rd Wat<br>not institution | on, give street and               | number)              | <u>e</u>         |             | - 4h     | o. City, Town, o                     | r Location    | of Death      | July 12, 2          |           | c County o                      | f Death                      |   |
|  |                | Laurel Region  |                           |                                   | ,                    |                  |             |          | Laurel                               |               |               |                     |           | Prince G                        |                              |   |
| Funeral  |                | 5. Social Security Nu  | ımber                     | 6. Sex                            | 7. Age               | (In yrs las      | t birthday  | y)       | If Under 1 Ye                        | ar If Unde    | er 24Hrs.     | 8. Date of B        | lirth(MM  | I/DD/YYYY)                      | (YYY) 9 Birthplace (State or |   |
| Director   |                | 214-32-78  | ΩΛΩ                       | 1X M 2 F                          |                      | 70               |             | Yrs.     | Months Da                            | ys Hours      | Min.          | June                | 11.       | n<br><sup>untry)</sup> Maryland |                              |   |
|  |                | Usual Residence of D   |                           |                                   |                      |                  |             |          |                                      |               |               |                     | ,         |                                 | L                            | 7 11011 1 20110                           |
| , any  |                | 10a. State   | 0b. County                |                                   | 1                    | Oc. City, T      | own or L    | ocatio   | n                                    |               |               |                     |           |                                 | $\neg$                       | 10d Inside City Limits                    |
| and<br>show  | 5              | MD   | Howa                      | ard                               |                      | La               | urel        |          |                                      |               |               |                     |           |                                 |                              | 1 Yes 2 X No                              |
| Maryland<br>28a-f show :<br>d at once.   | Director       | 10e. Street and Numi   | ber                       | -                                 |                      |                  |             |          | 10f. Zip Code                        |               |               |                     | 10g. Cit  | izen of Wh                      | at Coun                      | try?                                      |
| ith the Ma<br>23a or 23<br>notified  |                | 9049 Old   | Scago                     | sville R                          | oad                  |                  |             |          | 20                                   | 723           |               |                     |           | USA                             |                              |   |
| <b>21215-0036</b> uld be filed within 72 hours after death with the Maryland Mental Hyggene marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.                       | eral           | 11. Marital Status   |                           | 12. Was D                         | ecedent E<br>Forces? | ver in U.S.      | . 13.       |          | Decedent of H                        |               |               |                     | 0-        | 14. Race -<br>White             |                              | can Indian, Black,                        |
| r deat   | Fun            | 1 Never Married  |                           | 1 X Yes                           | 2                    | No               |             |          |                                      |               |               | icari, cic.)        |           | vviite                          |                              | 21.                                       |
| s afte<br>ral",<br>niner   | ò              | 3 Widowed  15 Decedent's Edu   | -                         | orced If Yes, Give Y<br>or Dates: |                      |                  | 1           |          | Yes 2 No                             |               |               |                     |           | Specify:                        |                              | ite                                       |
| hour hour  | Completed      | Elementary/Secon   |                           |                                   | (1-4 or 5+           |                  |             |          | s Usual Occupa<br>st of working life |               |               |                     | 16b.      | Kind of Bus                     | iness/Ir                     | ndustry                                   |
| 0036<br>within 72<br>iene<br>ner than<br>Medical   | l Die          | 10th   | (U-12)                    |                                   | Ø                    | ,                | Dr          | ive      | r                                    |               |               |                     | Gi        | dding                           | , c                          | Sons                                      |
| 15-0036<br>filed within 7<br>Hygiene<br>d other than   | 팃              | 17 Father's Name (F  | irst, Middle,             |                                   |                      |                  | DI          |          |                                      | 18.Mother     | 's Name (F    | irst, Middle,       |           |                                 |                              | 30115                                     |
| 21215<br>uld be file<br>Mental H<br>marked o   | Be             | William  | Matth                     | ew Somer                          | ville                | 9                |             |          |                                      | Lau           | ra Ed         | lna Gi              | ddin      | ıqs                             |                              |   |
| D 2121<br>should be fil<br>and Mental H<br>7 is marked   | 은              | 19a Informant's Nam  | ne/Relations              | hip (Type, Print)                 |                      |                  | 19b. Ma     | ailing / | Address (Stre                        |               |               |                     |           |                                 | , State,                     | Zip Code)                                 |
| MD<br>d 2 sho<br>lith and<br>in 27 is  |                | Jeanne A.  |                           | s /Niece                          |                      |                  | 86          | 91       | Pine T                               | ree R         | oad,          | Jessu               | р, М      | ID 20                           | 794                          |   |
| C 4 F 7  |                | 20a. Method of Dispo   | _                         | 3 Damoval                         | from State           |                  | ace of Dis  |          | on (Name of ce                       | emetery,      |               | Date                | 20c.      | Location - (                    | City or T                    | Town, State                               |
| Pages  |                |  |                           |                                   | IIOIII State         | -                |             |          | M Ch.                                | Cem.          | 7/18          | /2006               | S         | caggs                           | vil                          | le, MD                                    |
| Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr  |                | 4   Donation 5   Other Specify: Estatished of Circ. Cent.   7/16/2006   ScaggsVIII   21-Signature of Funeral Service Licensee   22. Name and Address of Facility   Donaldson Funeral Hom |                           |                                   |                      |                  |             |          |                                      |               |               |                     |           | me, P.A.                        |                              |   |
| <b>0</b> 8 8 E E   |                | Lance  | X4 / 11                   | 2000                              |                      | 01103            |             |          | Talbo                                |               |               |                     | -         |                                 | 070                          | 7   |
| Physician  |                | 23a. Part I. Enter the fallure. List only  | disease, or<br>one cause  | complications that on each line.  | caused th            | ne death. D      | o not en    | ter the  | mode of dying                        | , such as c   | ardiac or r   | espiratory ar       | rest, sho | ock, or hear                    | rt                           | Approximate Interval<br>Between Onset and |
| /Medical<br>Examiner   |                | Immediate Cause (Fi  |                           | a. Atheroscl                      | erotic C             | ardiovas         | scular i    | Dise     | ase                                  |               |               |                     |           |                                 |                              | Death                                     |
|  |                | or condition resulting   | in death)                 | Due to (or as                     | a conseq             | uence of):       |             |          |                                      |               |               |                     |           |                                 |                              |   |
|  | ē              | Sequentially list cond<br>if any, leading to imm   |                           | Due to (or as                     | a conseq             | uence of):       |             |          |                                      |               |               |                     |           |                                 | -                            |   |
| 19/  | 盲              | cause Enter Underly (Disease or injury that  |                           | e                                 |                      |                  |             |          |                                      |               |               |                     |           |                                 | 1                            |   |
| 1 -  | Examiner       | events resulting in de   | eath) Last                | Due to (or as                     | a conseq             | uence of):       |             |          |                                      |               |               |                     |           |                                 |                              |   |
| al an  | n/Medical      | UNPENDED   |                           | AMENDED                           | )                    |                  |             |          |                                      | · ·           |               |                     |           | _                               |                              |   |
| 8760, tificate be ng physicias the buri  | Med            | IF FEMALE:   |                           | 23c. If yes                       | , outcome            | of pregna        | incy        |          |                                      |               |               |                     | 23        | d Date of d                     | delivery                     |   |
| 687<br>certific<br>tding p   | an/            | 23b. Was decedent pr<br>past 12 months?  |                           | 1 Live                            | birth                |                  | 2           | Feta     | I death 3                            | Ectopic       | pregnanc      | y                   |           | Month                           | Dá                           | ay Year                                   |
| Box c death c the attened for us   | Physicia       | 1 Yes 2 No   | 9 Unk                     | nour =                            | gnant at tii<br>nown | me of deat       | h 5         | Othe     | er (Specify)                         |               |               |                     |           |                                 |                              |   |
| that the death certificated by the attending detached for use as   | 된              | Part II. Other signific  | cant condit               |                                   | _                    | out not resi     | ulting in t | he un    | deriving cause                       | given in Pa   | rt I          | 23e. Did t          | obacco    | use contrib                     | ute to th                    | ne cause of death?                        |
| ires that the signed by a be detacht   | <u></u>        | Emphysema  |                           |                                   |                      |                  |             |          |                                      | 0             |               |                     |           | _                               |                              | ibly 4 Unknown                            |
| ds,<br>requir  | Completed      |  |                           |                                   |                      |                  |             |          |                                      |               |               | 24a. Was            | an        | 24b. W                          | ere auto                     | ppsy findings available                   |
| tal Records cian: The law requ certificate has been  | dm             |  |                           |                                   |                      |                  |             |          |                                      |               |               |                     | ormed?    | de                              | ior to co<br>eath?           | mpletion of cause of                      |
| Rec<br>r: The liftcate l   |                | 25. Was case referred  | d to medica               | 1                                 |                      |                  |             |          | OS Dios                              | e of Death (  | (Charles      | 1 V Yes             | 2 N       | 0 1                             | ✓ Yes                        | 2 No                                      |
| sion of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certi death. ector: After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use as | Be             | examiner?  |                           | Hospital.                         | Inpatient            | 2 <b>V</b> E     | R/Outpat    | ient     |                                      | Other         | Nursing I     |                     | Rosida    | ence 6                          | Other:                       |   |
| 1 of Vi<br>ling Physi<br><br>After this<br>funeral dir   | ٤<br>ا         | 1 Yes 2<br>27. Manner of Death   | No                        | 28a. Dat                          | e of Injury          | 2                | 8b. Time    |          |                                      | ıry at Work   |               | 3d. Describe        |           |                                 |                              |   |
| on on arth.  | 틸              |  | 5 Pend                    | ling                              | th, Day,Yea          | ır)              |             |          | 1                                    | Yes 2         | No            |                     |           |                                 |                              |   |
|  | ig             | 2 Accident 3 Suicide   |                           | stigation 28e. Pla                | ace of Inju          | ry - At hom      | ne, farm, s | street,  | factory, office I                    | ouilding, etc | c. 28         | 3f. Location (      | Street a  | and Number                      | or Rura                      | al Route Number, City                     |
| Divi   | Certification: | 4 Homicide   |                           | mined (Specify                    | 1)                   |                  |             |          |                                      |               | ļ             | or Town,            | State)    |                                 |                              |   |
| Hosp<br>24 ho<br>Func<br>stely f   |                | 29a Certifier 1 C  | ertifying Ph              | nysician: To the be               | est of my l          | knowledge        | death o     | ccurre   | d at the time, d                     | ate and pla   | ce, and du    | e to the cau        | se(s) an  | id manner a                     | s starte                     | d.  |
| Div To the Hospital or within 24 hours afte To the Funeral Dir   | Medical        |  |                           | miner:On the basis<br>and manner  | s of exami<br>stated | nation and       | l/or invest | tigatio  | n, in my opinior                     | n, death oc   | curred at the | ne time, date       |           |                                 |                              |   |
|  | Σ              | 29b Signature and tit  | tle of certifie           | 1                                 |                      |                  |             |          | 29c. Licens                          | se number     |               |                     | 29d.      | Date signed                     | (Mont                        | h, Day, Year)                             |
|  |                | (20  | und                       | Wend                              |                      |                  |             |          | O.C.                                 | M.E.          |               |                     | July      | 13, 200                         | 6                            |   |
| 111  |                |  |                           | who completed ca                  |                      |                  |             |          |                                      |               |               | -                   |           |                                 |                              |   |
| 511  | لِي            | Laron Locke I  |                           | ssistant Medic                    |                      |                  |             | enn S    | Street, Baltii                       | more, MI      | 21201         |                     |           |                                 |                              |   |
| St<br>Regist   | ate<br>trar    | 31. Date filed (Month,   | L 2 1                     | 2006                              | egistrar's           | Signature        | 1           | 200      | 11.                                  |               |               |                     |           |                                 |                              |   |
| HMH 17 Rev 1/2   |                |  |                           |                                   |                      |                  | ORIGII      | NAI      | m T                                  |               |               |                     |           |                                 |                              |   |
| CME 2006   |                |  |                           |                                   |                      |                  | J UII       |          |                                      |               |               |                     |           |                                 |                              |   |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

|                                     |   | •              | For<br>State<br>Registrar  | State of Ma  | aryland /                        |                            | tment of r<br><i>ificate of</i>                 |  | Mental H                               | ygien<br>Reg. N   | -                          | J b                                 | 62931  |
|-------------------------------------|---|----------------|--|--|----------------------------------|----------------------------|---|--|--|-------------------|----------------------------|-------------------------------------|--|
| () .                                | Physicia  | an             | 1. Decedent's Name (First, Middle, Las   | •  |                                  | _                          |   |  | 2. Date of D<br>Month                  |                   | ay                         | Year                                | 3. Time of Death                                   |
|                                     | /Medic  | al             |  |  | Darwin S                         |                            |   |  | July                                   | -                 | & ZC                       | 06                                  | 2:00 M   |
|                                     | Examin  | er             | 4a. Facility Name (If not institution, give  | street and number)   | timore                           |                            | Baltor  | nove ()  |  | 4                 | ic. County                 | or Death                            |  |
|                                     | Funeral   |                | 5. Social Security Number 6. S   | ex 7. Ag   | e (In yrs. last bi               | irthday)_                  | If Under 1 Year                                 | If Under 24 Hr                                     | s. 8. Date of B                        | Birth             | e)                         | 9. Birthp                           | lace (State or Foreign                             |
|                                     | Director  |                | 199-24-3793  | <b>M</b> M 2□F   | 73                               | Yrs.                       | Months Days                                     | Hours Mir  | Oct 2                                  | 1, 1              | 932                        | Penn                                | sylvania   |
| pue                                 | W   | -              | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, Tov                   | wn or Loca                 | ation   |  |  |                   |                            | 10                                  | 0d. Inside City Limits                             |
| Mary                                | -faho   | ţō             | MD Baltimor  | `e   | Balti                            | more                       |   |  |  |                   |                            |                                     | 1 🙀 Yes 2 🗌 No                                     |
| the the                             | or 28a  | Director       | 10e. Street and Number   |  |                                  |                            | 10f. Zip Code                                   |  |  | 10g. (            | Citizen of W               | /hat Coun                           | try?   |
| ith wi                              | 23a c   | ralD           | 5225 Reisterstown  | Road   |                                  |                            | 21215   |  |  |                   | S.A.                       |                                     |  |
| hours after death with the Maryland | ital tygiene.<br>od other than "natural", or iteme 23a or 28a-f ahow<br>event, itte Medical Exactioer must be notified at | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Decedent<br>Armed Forces?<br>1 Tyes 2 XI<br>If Yes, Give<br>Year or Dates: |                                  |                            | as Decedent of Ness, specify Cub                | Hispanic Origin? (<br>an, Mexican, Pue<br>Specify: | Specify Yes or North Rican, etc.)      | 10-               | Blac                       | - Amenc<br>k, White, d<br>Whit      |  |
|                                     | natur   | eted           | 15. Decedent's Ed<br>(Specify only highest gra   |  | 16a                              | a. Decede                  | int's Usual Occup<br>and of work done           | pation<br>during most of w                         | orking                                 | 16b.              | Kind of Bu                 | siness/Inc                          | dustry   |
| tiled within 72 hours at            | han.  | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5   | 5+)                              |                            |   | <sub>d)</sub><br>intractoi                         |  | FI                | .ectri                     | cal                                 |  |
|                                     | Hygie<br>other<br>ent,  | ပိ             | 17. Father's Name (First, Middle, Last,  |  | 1                                | 10001                      | 1041 00   |  | ame (First, Midd                       |                   |                            |                                     |  |
| d 2 should be file                  |   | То Ве          | Joseph Howard  | Swaney   |                                  |                            |   | Anna M   | Mae Worm                               | an                |                            |                                     |  |
| S should                            | PEE   | 14             | 19a. Informant's Name/Relationship (   | Туре, Print)   | 19                               | b. Mailing                 | Address (Street                                 | and Number or I                                    |  |                   | or Town,                   | State, Zip                          | Code)  |
|                                     |   |                | Ava Yvette Giffor  | d /daughte   |                                  |                            |   | od Way,  |  | +                 |                            |                                     |  |
| Dane 1 al                           |   |                | 20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)                                       | y)   |                                  | Arund                      | tion (Name of<br>atory or other pla<br>del Crem | 7/2  | Date 22/2006                           | Ode               | enton,                     |                                     | wn, State  |
|                                     | Department important: if any injury o   |                | 21. Signalure of Furein Service Lion   | ns of  | M0077                            |                            |   | ss of Facility<br>Funeral<br>ott Ave.              |  |                   |                            | 1 207                               | 07-4389  |
|                                     | hysician  |                | 23a. Part1. Enter the disease, or com<br>shock, or heart tallure. List only<br>Immediate Cause (Pinal<br>disease or condition        | plications that caused<br>one cause on each li                                     | the death. Do                    |                            | 17  | ng, such as cardi                                  |  | arrest,           |                            |                                     | Approximate<br>Interval Between<br>Onset and Death |
|                                     | Medical xaminer   |                | resulting in death)  | Due to (or as  | a consequence                    | of O                       |   |  |  |                   |                            |                                     | 1  |
| d.                                  |   | jer            | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c. |  |                                  |                            |   |  |  |                   |                            |                                     |  |
| tificate be executed                | g physicien and as the burial-transit   | Examiner       |  |  |                                  |                            |   |  |  |                   |                            |                                     |  |
| aya ac                              | cien a  |                | resulting in death) Last   | Due to (or as  | Due to (or as a consequence of): |                            |   |  |  |                   |                            |                                     |  |
| ficate he e                         | physics the b   | edical         |  | d  |                                  |                            |   |  |  |                   |                            |                                     |  |
| death car                           | e attendin<br>d for use   | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 23c. If yes, outcome<br>1 Live birth<br>4 Pregnant at<br>9 Unknown                 | 2 Fetal deat                     |                            | Ectopic pregnand<br>Other (specify)             | у  |  |                   | 23d. Date<br>Mor           | e of delive                         | ry<br>Day Year                                     |
| The lew requires that the           | igned by<br>be detac  | þ              | Part II. Other significant conditions  | contributing to death b  | out not resulting                | in the und                 | derlying cause gr                               | ven in Part I.                                     |  |                   |                            |                                     | ne cause of death?                                 |
| to low requires :                   | been si<br>should I   | eted           |  |  |                                  |                            |   |  |  |                   |                            |                                     | ably 4 □Unknown                                    |
|                                     |   | Completed      |  |  |                                  |                            |   |  | 24a. We aut per                        | topsy<br>rformed? |                            | Vere autor<br>rior to cor<br>leath? | osy findings available inpletion of cause of       |
| iolen.                              | certificete<br>rector, pag  | Be             | 25. Was case referred to medicat examiner?   | Hospital:  |                                  |                            | D   |  | eath (Check only                       | у опе)            |                            |                                     |  |
| 5                                   | this<br>raidii  | lon: To        | 1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending  | 28a. Date of Inju<br>(Month, Da  | iry 28b.                         | Time of<br>Injury          | 28c. Inju                                       | ry at  | Home 5 Re                              |                   |                            |                                     | ()   |
| O WISHOUT                           | tor:<br>the   | Certification: | 2 Accident Investigatio 3 Suicide 6 Could not be 4 Homicide determined   | e 28e. Place of In   | jury - At home, t                | farm, stree                |   | ]Yes 2∏No  | 28f. Location<br>City or 7             |                   |                            | er or Rura                          | l Route Number,                                    |
| S Pales                             | hours after<br>uneral Dire  |                |  |  |                                  |                            |   |  |  |                   |                            |                                     |  |
| 907                                 | 4 T 0   | Medical        | 29a. Certifier 1 Certifying Pl<br>(Check only 2 Medical Example)   | nysician: To the best<br>miner: On the basis o<br>and manner st                    | of examination a                 | ge, death o<br>und/or inve | occurred at the testigation, in my              | ime, date and pla<br>opinion, death oc             | ce, and due to th<br>curred at the tim | e, date a         | (s) and ma<br>and place, a | nner as st<br>and due to            | ated.<br>the cause(s)                              |
| Tothe                               | To the comp   | Me             | 29b. Signature and tille of certifier  | 0  |                                  |                            | 1   | se number  |  | Į.                | Date signed                |                                     |  |
|                                     |   |                | Latha M  | off, MI  | >                                |                            | RES   | 5-00C  | )                                      | Ju                | les                        | 18,                                 | 2006   |
|                                     | 3   |                | 30. Name and address of person who   | completed cause of o   | Seath (Item 23a)                 | (Type, P                   | Hospita   | S-000  | 200 for                                | nar               | 0                          |                                     |  |
| 4                                   | Sta   | ate            | 31. Date filed (Month, Day, Year)  | 32. Registr  | rar's Signature                  |                            | . 100/01/10                                     | 0  | sucy 111                               | (00               |                            |                                     |  |
|                                     | Registi   | rar            | 0 1 000  |  | lie                              | Lugar                      | P .   |  |  |                   |                            |                                     |  |

1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death SCHIMPF ,Jr YAUT **Physician** 2006 WILLIAM FREDERICK 5:30 A /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center Examiner If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Aug. 22, 1920 9. Birthplace (State or Foreign **Funeral** Months 1**X**1M 2□F Days Hours Min. Maryland 216-16-2613 85 Director Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10h Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at MD Parkville Baltimore 1 ☐ Yes 2X No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8017 Oakleigh Road 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 March 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MTA Dispatcher 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any light or other traumatic event space. Be William Frederick Schimpf, Sr Hortense Brice Creamer ္က 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Joan Schimpf-spouse 8017 Oakleigh Road-Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 7-22-06 Moreland Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 8800 Harford Road Farkville, MD 21234 LME Fadde and rai 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying; such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onser and Death END STAGE RENAL DISEASE Physician /Medical Due to (or as a consequence of): SEPSIS Examiner MONTHS S. pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending physic 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 □Unknown CARDIOMYOPATHY 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perforn 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٩ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59297 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL CHAN, ,7601 OSLER DRIVE M.D. TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) Registrar's Signature State 2006

Registrar

|            |  |                   | Please T   | ype or Pri   |   |                          |  |                              |            | -                                      |                        | •                               |  |    |
|------------|--|-------------------|--|--|---|--------------------------|--|------------------------------|------------|--|------------------------|---------------------------------|--|----|
|            |  |                   | 1 - For<br>State<br>Registrar  | State of M   | aryland /                               |                          | irtment of H<br>tificate of I                      |                              |            |  | giene<br>Reg. No       | 4000                            | 2293   | 3  |
|            | Dhysisi  |                   | 1. Decedent's Name (First, Middle, Last)   |  |   |                          |  |                              |            | 2. Date of De<br>Month                 | Da                     | y Year                          | 3. Time of Death                                   |    |
|            | Physici<br>/Medic  |                   | William G. St  |  |   |                          |  |                              |            | July                                   | 18,                    | 2006                            | 6:30 A   | 4  |
| L          | Examin   | er                | 4a. Facility Name (If not institution, give :  | street and number)   |   |                          | 4b. City, Town, or                                 | r Location of                | of Death   |  | 4c.                    | . County of Dee                 | h  |    |
|            |  |                   | 9500 Holsey Road   |  |   |                          | Damascus   |                              | 0711 - 1   |  |                        | ontgome                         |  |    |
| L          | Funeral<br>Director  |                   | 267-36-8828  | 7. Ag  | ge (In yrs. last)<br>75                 | Yrs.                     | If Under 1 Year<br>Months Days                     | If Under<br>Hours            | Min.       | 8. Date of Bir<br>(Month, Da<br>Feb. 1 | ay, Year)              | 9. Bin<br>Co<br>31 Flo          | hplace (State or Foreigi<br>untry)<br>rida         | ın |
|            | pue *  |                   | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, To                           | own or Lo                | cation   | -                            |            |  |                        |                                 | 10d. Inside City Limits                            | c  |
|            | be filed within 72 hours atter death with the Maryland nat Hygiene. do other then "neturel", or Items 23s or 28s-f show event, the Mediral Exam har must be notified at  | Funeral Director  | MD Montgome  | ry   | Dama                                    | scus                     | 7.5.2.2  |                              |            |  |                        |                                 | 1 ☐ Yes 2 🛣 No                                     |    |
|            | Nith t   | ā                 | 10e. Street and Number   |  |   |                          | 10f. Zip Code                                      |                              |            |  | 10g. Cit               | tizen of What Co                | untry?   |    |
|            | s 23   | era               | 9500 Holsey Road   | 12. Was Decedent   | Function III C                          | 12.1                     | 20872  | ti- O-t                      | -1-0 (0-   | -t -V N-                               |                        | USA                             |  |    |
|            | Item   | 'n.               | 11. Marital Status 1 ☐ Never Married 2 ☐ Married   | Armed Forces?  | ?                                       | "                        | Vas Decedent of H<br>Yes, specify Cuba             | in, Mexican                  | n, Puerto  | Rican, etc.)                           | )-                     | 14. Race - Ame<br>Black, Whit   |  |    |
| 36         | urs at   | by F              | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:                                   |   | 1                        | ☐ Yes 2☐ No  | Specify:                     | whi        | te                                     |                        | Specify:                        | hite   |    |
| 9          | 2 hou  | ted               | 15. Decedent's Edu   | cation   | 16                                      | Sa. Deced                | ent's Usual Occup                                  | ation                        |            |  | 16b. K                 | ind of Business                 |  |    |
| 21215-0036 | 2 should be filed within 7<br>and Mental Hygiene.<br>Is marked other then "n<br>eumatic event, the Med   | Completed         | (Specify only highest grade<br>Elementary/Secondary (0-12)   | Cotlege (1-4or<br>5+   |   | life. L<br>resid         | kind of work done of<br>20 NOT use retired<br>dent | during mosi<br>1)            | t of worki | ng                                     | Но                     | spital                          |  |    |
|            | othe<br>othe   | 60                | 17. Father's Name (First, Middle, Last)  |  |   |                          |  | 18. Mothe                    | r's Name   | (First, Middle                         |                        |                                 |  |    |
| Maryland   | ould be i<br>Mental I<br>arked o   | ToB               | Alfred Straight  |  |   |                          |  | Le                           | ena I      | Brooks                                 |                        |                                 |  |    |
| ary        | should<br>and Men<br>s marke<br>umatic   |                   | 19a. Informant's Name/Relationship (Ty   | oe, Print)   | 1                                       | 9b. Mailin               | g Address (Street a                                | and Numbe                    | or Rura    | l Route Numb                           | er, City o             | or Town, State, 2               | (ip Code)  |    |
|            | 1 and 2<br>Health a<br>tem 27 ls   |                   | Carol Straight -   | Wife   |   | 9500                     | Holsey F   | Road I                       | Damas      | cus, M                                 | ary1                   | and 208                         | 72   |    |
| altimore,  | es 1 ar<br>of Hea<br>f Item ;  |                   | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R  |  | 20b. Place                              | of Dispos                | sition (Name of natory or other plac               |                              |            | ate                                    |                        | ocation - City or               |  | _  |
| Ĕ          | Pages<br>nent of I<br>ent: If It<br>ury or o   |                   | '4 □Donation 5 □Other (Specify)  | emoval nom State   |   | o Cr                     | ematory  |                              | July       | 20. 06                                 | Ba1                    | timore,                         | MD   |    |
| Salt       | permit. Pages 1 and 2 should<br>Department of Health and Men<br>Importent: If Item 27 is marke<br>any injury or other treumatic<br>000.0.  |                   | 21. Signature of Funeral Service Leense  | 100  |   |                          | Name and Addres                                    | ss of Facilit                | у          |  |                        |                                 |  |    |
| 8          | 20 E E G   |                   | MIL AG   | Mang   | u                                       |                          | Cremation<br>299 Frede                             | i Soci<br>Prick              | Roac       | or Mar<br>Balti                        | yıan<br>more           | $\frac{1}{1}$ MD 21             | 228  |    |
|            | Physician<br>/Medical  |                   | 23a. Pann. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) | Lower  |   | str                      | of the mode of dying                               | g, such as                   | cardiac o  | r respiratory a                        | rrest,<br>1.<br>1nd    |                                 | Approximate<br>Interval Between<br>Onset and Death |    |
| 4          | Examiner   | er                | Sequentially list conditions, if any, leading to immediate   | Anem   | i d                                     | e of):                   |  |                              |            |  |                        |                                 |  |    |
|            | outed<br>nd<br>ransit  | Examine           | cause. Enter Underlying Cause (Disease or injury that initiated events   | Atria  | 1 1                                     | ibri                     | Hation   | 7                            |            |  |                        |                                 |  |    |
| 60,        | be exe<br>icien a<br>burial-   | _                 | resulting in death) Last   | Cohona<br>Cohona   | a consequence                           | e of):                   | Long o   | liser                        | 100        |  |                        |                                 |  |    |
| 09289      | phys<br>phys<br>s the  | dlc               |  | COTOTI   | 11 4                                    | all                      | ery u  | 1000                         | 100        |  |                        |                                 | <u> </u>   |    |
| P.O. Box ( | that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 3c. If yes, outcome<br>1 Live birth<br>4 Pregnant a<br>9 Unknown | 2 Fetal dea                             |                          | Ectopic pregnancy<br>Other (specify)               |                              |            |  |                        | 23d. Date of del<br>Month       | very<br>Day Year                                   |    |
|            | Se Pe es   | by                | Pan II. Other significant conditions con   | 11   |   | g in the ur              | iderlying cause give                               | en in Part I.                |            |  | ,                      | ,                               | the cause of death?                                |    |
| orc        | v requir<br>been si<br>should  | eted              | ParKinson's c  | liseas   | E                                       |                          |  | ·····                        |            | 10                                     | Yes 2                  | No 3□Pr                         | obably 4 Unknown                                   | 1  |
| Records,   | : The law<br>cate has t<br>page 2 s  | Completed         |  |  |   |                          |  |                              |            | 24a. Was<br>autor<br>perfo             |                        | prior to death?                 | topsy findings available<br>completion of cause of | Э  |
| Vital      | Physician: Th<br>this certiticate<br>ral director, pag   | Bec               | 25. Was case referred to medicat examiner?   |  |   |                          |  | 26. Place                    | of Death   | (Check only o                          |                        | 10.00                           | -54.10   |    |
| of V       | S S  | Tof               | 1 Yes 2 No   | ospital: 1 🔲 Inpatie   | ent 2 ER/                               | Outpatient               | 3 DOA Othe   | er: 4 🗆 Nu                   | rsing Hor  | ne 5 Resid                             | dence                  | 6 ☐Other (Spe                   | afy)   |    |
|            |  | on:               | 27. Manner of Death 1 Natural 5 ☐ Pending  | 28a. Date of Inju<br>(Month, Da                                  | yry 28t                                 | Time of<br>Injury        | 28c. Injury<br>Work                                | at<br>c?                     | 2          | 8d. Describe                           | how injur              | y occurred                      |  |    |
| sio        | uttendi<br>death.<br>ctor: A<br>y the tu   | cat               | 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be  |  |   |                          | M 1 🗆 '  | Yes 2 1                      | No         |  |                        |                                 |  |    |
| Division   | al or Attendation distribution of the control of th | Certification:    | 4 Homicide determined  | 28e. Ptace of In<br>building, e                                  | jury - At home,<br>tc. <i>(Specify)</i> | farm, stre               | eet, factory, office                               |                              | 2          | 28f. Location (:<br>City or Tox        | Street an<br>vn, State | d Number or Ru<br>)             | ral Route Number,                                  |    |
|            | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely tilled in by the tune   | Medical C         | 29a. Certifier 1 Certifying Physics (Check only one)   | sician: To the best<br>ter; On the basis of<br>and manner st     | of examination.                         | lge, death<br>and/or inv | occurred at the timestigation, in my op-           | ne, date and<br>pinion, deat | d place, a | and due to the ed at the time,         | cause(s)<br>date and   | and manner as<br>place, and due | stated.<br>to the cause(s)                         |    |
|            | To Toon  | 2                 | 29b. Signature and title of certifier  | Tomsk  | to M                                    | ry, h                    | 29c. License                                       | 5 / 4                        | 916        |  | 29d. Dat               | te signed (Mont)                | , Day, Year)<br>7 2006                             |    |
|            | Sta  | ite               | 30 Name and address of person who control of Tomski. 31. Date filed (Month, Day, Year)   | 0 Nay, 1   | death (ttem 23a<br>rar's Signature      | Roc                      | Kville,  | Pike                         | 6-         | 100, K                                 | lock                   | Kville,                         | MD 2085:   | 2  |
|            | Registr  |                   | JUL 2 1 200  | b Com  | an St                                   | 140                      |  |                              |            |  |                        |                                 |  |    |

Registrar DHMH 17 Rev 1/2001

|                   |   |                  | For State Registrar   | State of Ma  | arylan             |   | artment<br>rtificate                       |                        |                          | and M              | ental Hy                         | giene<br>Reg. No.        | 2005                          | 22934  |
|-------------------|---|------------------|---|--|--------------------|---|--|------------------------|--------------------------|--------------------|----------------------------------|--------------------------|-------------------------------|--|
| ¢.                | Physicia  | an               | 1. Decedent's Name (First, Middle, La   |  |                    |   |  |                        |                          |                    | 2. Date of D<br>Month            | Dav                      | Year                          | 3. Time of Death                                 |
|                   | /Medic  | ai               | Minglong  4a. Facility Name (If not institution, giv  | Su street and number   |                    |   | 4b. City, T                                | OWD OF                 | Location o               | of Death           | July                             | 18,                      | 2006<br>County of Dea         |  |
| A.                | Examin  | er               | 8634 Cobblefie  |  | pt                 | 1 B                                     | Colu                                       |                        |                          | , Bouil            |                                  |                          | loward                        |  |
| 5.                | Funeral   |                  | Social Security Number     6. S   | ex 7. Age  | (In yrs.           | last birthday)                          | If Under 1                                 |                        | If Under 2               | 24 Hrs.<br>Min.    | 8. Date of B                     |                          |                               | rthplace (State or Foreign ountry)               |
|                   | Director  |                  | 685-07-1418   Usual Residence of Decedent   | X M 2□F  | 69                 | Yrs.                                    |  |                        |                          |                    | MAR :                            | 12,1                     | 937 (                         | China  |
|                   | yland<br>low  |                  | 10a. State 10b. County  |  | 10c. Cit           | y, Town or Lo                           | cation                                     |                        |                          |                    |                                  |                          |                               | 10d. Inside City Limits                          |
|                   | e Man   | ctor             | MD Howard   | 1  | Со                 | lumbi                                   | a  |                        |                          |                    |                                  |                          |                               | 1 ☐ Yes 2 No                                     |
|                   | ifer death with the Marylan<br>r Iteme 23a or 28a-f show<br>illner roast by ricitified at   | Dire             | 10e. Street and Number  |  |                    |   | 10f, Zip (                                 |                        |                          |                    |                                  |                          | zen of What C                 | ountry?  |
|                   | eath v  | erai             | 8634 Cobblefie  | eld Dr. A  |                    |   | 210  |                        | enanic Orig              | nin? (Sne          | orfy Yes or N                    |                          | ina<br>14. Race - Am          | erican Indian                                    |
| (0                | after dea<br>or Iteme   | Funeral Director | 1 Never Married 2 Married   | Armed Forces? 1 ☐ Yes 2√ N If Yes, Give Λ                      |                    |   |  |                        |                          | , Puerto           | ecify Yes or N<br>Rican, etc.)   |                          | Black, Whi                    |  |
| 93                | ours a  | d by             | 3 Widowed 4 Divorced  | Year or Dates:   |                    |   | 1 🗆 Yes 2                                  | XNO                    | Specify:                 |                    |                                  |                          |                               | sian   |
| 21215-0036        | within 72 hours after death with the Maryland<br>ane.<br>then "natural", or Iteme 23a or 28a-f show<br>the Medical Exertiner roast be molified at | Completed        | 15. Decedent's E<br>(Specify only highest gra   |  |                    | 16a. Deced                              | dent's Usual<br>kind of work<br>DO NOT use | Occupa<br>k done di    | tion<br>uring most       | t of worki         | ng                               | 16b. Ki                  | nd of Business                | s/Industry                                       |
| 12                | iene.   | omp              | Elementary/Secondary (0-12)   | College (1-4or 5   | +)                 | Engi                                    |  | , , , , ,              |                          |                    |                                  | Tra                      | ctor Ma                       | nufacturer                                       |
| pu                | be filed within 72 hours a<br>Ital Hygiene.<br>Id other then "naturel", o<br>event, the Medical Exer  | Be C             | 17. Father's Name (First, Middle, Last  | )  |                    |   |  |                        | 18. Mothe                | r's Name           | (First, Middle                   | e, Maiden                | Sumame)                       |  |
| yla               | should band Ment<br>and Ment<br>marked<br>umatic e  | P.               | Yuti Su   |  |                    |   |  |                        |                          | ngqi               |                                  | heng                     |                               |  |
| Maryland          | d 2 sh<br>th and<br>7 is rr<br>traurr   |                  | 19a. Informant's Name/Relationship (  |  |                    | 100                                     |  |                        |                          |                    |                                  |                          |                               | <sup>Zip Code)</sup> 21045                       |
| αĵ                | ges 1 and 2 should<br>it of Health and Men<br>if item 27 is marke<br>or other traumatic   |                  | Rongfen Jia/wi  | rre  | 20b. F             | OOJ<br>Place of Dispo<br>cemetery, crer | sition (Nami                               | e of                   |                          | ם ם                | r. Ap                            | 20c. Lo                  | cation - City o               | mbia, MD<br>r Town, State                        |
| OE.               | Pages<br>nent o<br>int: If<br>iry or  |                  | 1 ☐ Burial 2 【XCremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Special   |  |                    | etro C                                  | -  |                        |                          | c <b>7/</b>        | 19/06                            | Ва                       | altimo                        | ore, MD  |
| Baltimore,        | permit. Pages Department of h Important: If ite ony injury or of  |                  | 21. Signature of Funeral Service Lice   | rseeC. Todd  | Dri                | ng C                                    | remat                                      | Addres                 | s of Sacility            | iet                |                                  |                          | land,                         |  |
|                   | 205 a   |                  | 23a. Part1. Enter the disease, or com   |  | the deat           | 129                                     | 99 Fr                                      | ede                    | rick                     | Rd                 | Cato                             | nsvi                     | 11e, ´                        | MD 21228<br>Approximate                          |
|                   |   |                  | shock, or heart failure. List only  | one cause on each lir  | 10.                |   |  |                        |                          |                    |                                  |                          |                               | Interval Between<br>Onset and Death              |
| de                | Physician<br>/Medical   |                  | disease or condition resulting in death)  | Due to (or as  |                    | STAT                                    | IC   | LU                     | 1007                     | CI                 | TNCE                             | 72_                      |                               | 4 Months   |
|                   | Examiner  |                  | Sociantially list conditions  | b  |                    | 190                                     |  |                        |                          |                    |                                  |                          |                               |  |
|                   | 8 V 5   | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as  | a conseq           | uence of):                              |  |                        |                          |                    |                                  |                          |                               |  |
| _^                | al-tran   | Examine          | that initiated events<br>resulting in death) Last   | c. Due to (or as   | a conseq           | uence of):                              |  |                        |                          |                    |                                  |                          |                               |  |
| 68760             | cate be executed bhysician and the burial-transit   | cai              |   | _ d  |                    |   |  |                        |                          |                    |                                  |                          |                               |  |
| 68                | ing ph  |                  | IF FEMALE:  |  |                    |   |  |                        |                          |                    |                                  |                          |                               |  |
| Вох               | death certifica<br>e attending ph<br>id for use as ti   | Physician/Med    | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant at      | 2 Feta             | ıl death 3□                             | Ectopic pre Other (spe                     |                        |                          |                    |                                  | 4                        | 23d. Date of de<br>Month      | Day Year   |
| o.                | that the de-<br>ned by the a<br>detached f  | ysic             | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9□ Unknown   | time or d          | leadi J                                 | 3 Other (spe                               | rcity)                 |                          |                    |                                  |                          |                               |  |
| s, P              | law requires that the<br>as been signed by th<br>2 should be detache  | by Pi            | Part II. Other significant conditions   | contributing to death bi                                       | ut not res         | ulting in the u                         | nderlying ca                               | use give               | n in Part I.             |                    | 23e. Did                         | tobacco u                | se contribute t               | to the cause of death?                           |
| ord               | w require<br>been si<br>should?   |                  |   |  |                    |   |  |                        |                          |                    | 1/2                              | Yes 2[                   | □No 3□P                       | robably 4 Unknown                                |
| of Vital Records, | has b   | Completed        |   |  |                    |   |  |                        |                          |                    |                                  | s an<br>opsy<br>formed2/ | 24b. Were a prior to death?   | utopsy findings available completion of cause of |
| lal               | ician: The liceration of sector, page   | e Co             | 25. Was case referred to medical  |  |                    |   |  |                        | GC Disease               | of Dooth           | 1 □ Yes                          | 2 No                     | 1 □ Ye                        |  |
| Ž                 | S S   | To B             | examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)  | Hospital:  | nt 2 🗆             | ER/Outpatier                            | nt 3 🗆 DO/                                 | A Othe                 | F                        |                    | ne 5 Res                         |                          | 5 □Other (Spe                 | ecify)   |
|                   | ding Phy<br>h.<br>After thi<br>funeral  | •                | 27. Manner of Death 1 ☑Natural 5 ☐ Pending  | 28a. Date of Injur<br>(Month, Da)                              | y<br>Yea <i>r)</i> | 28b. Time of<br>Injury                  |  | Bc. Injury<br>Work     |                          | 1                  | 28d. Describe                    | how injur                | y occurred                    |  |
| Division          | Attending<br>r death.<br>ector: After<br>by the fune  | icat             | 2 Accident investigation 3 Suicide 6 Could not be   | e 200 Place of lais  | Inv - At h         | ome farm str                            | M factory                                  |                        | ′es 2 🔲 l                |                    | 28f Location                     | (Street an               | d Number or S                 | Tural Route Number,                              |
| Di∨               | after<br>Direction by   | Certification:   | 4 Homicide determined   | building, etc  | . (Speci           | (y)                                     | cor, raciory,                              | Onico                  |                          |                    |                                  | own, State               |                               |  |
|                   | To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the  | edical C         | 29a. Certifier 1 Certifying Pl<br>(Check only one) 2 Medical Exe  | nysicien: To the best of miner: On the basis of and manner sta | examina            | owledge, death<br>ation and/or in       | h occurred a<br>vestigation,               | at the tim<br>in my op | e, date an<br>inion, dea | d place, th occurr | and due to the<br>ed at the time | e cause(s)<br>, date and | and manner a<br>place, and du | s stated.<br>e to the cause(s)                   |
|                   | To the within 2 To the complet  | Me               | 29b. Signature and title of certifier   | 21.  |                    |   | 29c.                                       | License                | number                   | ,                  | ,                                | 29d. Dat                 | e signed (Mon                 | th, Day, Year)                                   |
| •                 | $\circ$   |                  | , ce  |  | •                  |   |  | UI                     | 63                       | 54                 | +                                | _/                       | 119/                          | 2006   |
|                   | 7   |                  | 30. Name and address of person who  | STAG   | eath (Iter         | S Q                                     | Print)                                     | A                      | TON                      | AVE                | BI                               | 7LT.                     | MD                            | 2006   |
| No.               | Sta<br>Registi  |                  | 31. Date filed (Month, Day, Year)  JUL 2 1 2  | 006 32. Jegistra   | ar s Signa         | B 4                                     | meli                                       |                        |                          |                    |                                  |                          |                               |  |

|                            |  |                   | 1 - For Amend #8&10c  | State of Ma<br>Per FH G8   | ryland/D<br>358 8/02            | epartmei<br>Centifica                             | nt of H<br>te of L  | ealth a<br>Death     | and Mei       | ntal Hyg                   | jiene /    | 2006               | 22                                      | 935                  |
|----------------------------|--|-------------------|---|--|---------------------------------|---|---------------------|----------------------|---------------|----------------------------|------------|--------------------|---|----------------------|
|                            |  |                   | 1. Decedent's Name (First, Middle, Last   |  |                                 |   | -                   |                      |               | Date of Dea<br>Month       |            | Year               | 3. Time of                              | Death                |
|                            | Physici:<br>/Medic   | -                 | COZETTE JONES   | SWANN  |                                 |   |                     |                      |               | JULY                       | 15,        | 2006               | 11:30                                   | P M                  |
|                            | Examin   |                   | 4a. Facility Name (If not institution, give   |  |                                 | ,   |                     | Location of          | of Death      |                            | 4c. Co     | ounty of Death     |   |                      |
|                            |  |                   | Southern Maryland   |  | //= last birt                   |   | nton<br>or 1 Year   | If Under 2           | 24 Hrs D      | Date of Birth              |            | P.G.               | nlann (Ctata n                          |                      |
|                            | Funeral<br>Director  |                   | 5. Social Security Number 6. Se 1578-28-6019  | X<br>☐M 2☐F /.Age  | In yrs. last birti<br>83        | rs. Months  |                     | Hours                | Min. Ja       | Date of Birth              |            | T.T T              | place (State o<br>ntry)<br>ington       | _                    |
|                            |  |                   | Usual Residence of Decedent   |  |                                 |   | 1 1                 |                      |               | dire Z.                    | , 192      | 3   Wash           | Tilgcon                                 |                      |
|                            | rylan  |                   | MARYLAND P.G.   |  | 10c. City, Town                 |   | -Danier             | o E4                 |               | 1. d 4                     | MT         |                    | 10d. Inside Ci                          |                      |
|                            | Ba-f e   | cto               |   |  | 12007 1                         | lickory   |                     | e, rt                | . was         |                            |            |                    | 1 ⊠Yes                                  | 2   NO               |
|                            | vith th  | Dire              | 10e. Street and Number  |  |                                 |   | p Code<br>20744     |                      |               | 1                          |            | n of What Cou      | ntry?                                   |                      |
|                            | sath v   | erai              | 12007 Hickory Driv  | 12. Was Decedent E   | ever in U.S.                    | 13. Was Dece                                      |                     | spanic Orio          | nin? (Specif  | v Yes or No-               |            | JS<br>Race - Ameri | can Indian.                             |                      |
|                            | ther d   | Funeral Director  | 1 Never Married 2 Married   | Armed Forces?<br>1 ☐ Yes 2 X N                                       | 0                               | If Yes, sp  | ecify Cubai         | n, Mexican,          | , Puerto Rio  | an, etc.)                  |            | Black, White,      |   |                      |
| 5-0036                     | el', o   | þ                 | 3 ☐ Widowed 4 Ž Divorced  | If Yes, Give<br>Year or Dates:                                       |                                 | 1 ☐ Yes   | 2XI No              | Specify:             |               |                            | S          | Ind:               |   |                      |
| 2                          | 72 hc  | etec              | 15. Decedent's Edi<br>(Specify only highest grad  |  | 16a.                            | Decedent's Usi<br>(Give kind of w<br>life. DO NOT | al Occupa           | ation<br>furing most | of working    |                            | 16b. Kind  | of Business/Ir     | ndustry                                 |                      |
| 121                        | within 72 hours after death with the Maryland<br>ene.<br>Than "naturel", or items 23a or 28a-f ehow<br>In Medical Evantinar must be notitled at  | Be Completed      | Elementary/Secondary (0-12)   | College (1-4or 5-  | +)                              | Homen   |                     | )                    |               |                            | Priv       | ate                |   |                      |
| 75<br>17                   | Hygie<br>Hygie<br>other 1  | ပိ                | 17. Father's Name (First, Middle, Last)   |  |                                 | пошещ   | aker                | 18. Mothe            | r's Name (F   | First, Middle,             | Maiden Su  | ımame)             |   |                      |
| aŭ                         | d be i | To Be             | Albert Jones  |  |                                 |   |                     | Nano                 | cy Dil        | llie Jo                    | ones(      | Dixon)             |   |                      |
| Maryland 2121              | 2 should be filed within 72 hours after death with the Marylan and Menial Hygiens. Is marked other than "naturet", or items 23s or 28s-1 show as marked other than "naturet", or items 23s or 28s-1 show aumatic event, the Madical Examinat must be notitled at   | _                 | 19a. Informant's Name/Relationship (T   | ype, Print)  |                                 | Mailing Addres                                    |                     |                      |               |                            |            |                    | o Code)                                 |                      |
| Σ                          | and 2<br>Balth<br>n 27 i   |                   | Phoenicia Jones   |  |                                 | 007 Hic   |                     | Drive                |               | _                          |            |                    | 20744                                   |                      |
| altimore,                  | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a <u>pnce</u> .   |                   | 20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,   |  | cemeter                         | Disposition (Na<br>y, crematory or<br>rrectio     | other place         |                      | Date<br>7 / 2 |                            |            | tion - City or T   | own, State                              |                      |
| <u>=</u>                   | mit. F<br>sartme<br>sortan<br>/ injur  |                   | 21. Signature of Funeral Service Licens   |  |                                 |   |                     |                      |               |                            |            | ral Hor            | ne, Inc                                 | 2.                   |
| Ä                          | P P P P P P P P P P P P P P P P P P P  |                   | Deshoup   | (1) att  | <u>A</u>                        | 389 Rh  | ode I               | [sland               | d Aven        | ue, N.                     | . W.,      | Wash.,             | D.C.                                    | 20001                |
| 8760, <                    | Physician who investigate the provided the private in the private  | Ilcal Examiner    | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a c.   | consequence of a consequence of | э <del>с</del> С                                  |                     |                      |               |                            |            | 2                  | Approximation interval Beto Onset and I | ween                 |
| P.O. Box 68                | The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown   | 23c. If yes, outcome of 1 □ Live birth 1 4 □ Pregnant at 9 □ Unknown | 2 Fetal death                   | 3 ⊟Ectopic (                                      |                     |                      |               |                            | 230        | d. Date of deliv   | <u>.</u>                                | Year                 |
|                            | res that<br>igned b<br>be deta   | by Pt             | Part II. Other significant conditions co  | ontributing to death bu  | ut not resulting in             | the underlying                                    | cause give          | en in Part I.        |               | 23e. Did to                | bacco use  | contribute to t    | he cause of d                           | leath?               |
| ğ                          | w require<br>been sig<br>should b  |                   | Benedles  | Agge   | وت                              | reed?   | /                   |                      |               | 1 🗆 Y                      | es 2 🗗     | No 3□ Prol         | bably 4 □U                              | Jnknown              |
| ဝင္                        | has be   | Completed         | /orpollying   | edies  | Some                            | na/   | 125                 | 2                    | elek.         | 24a. Was a                 |            | 24b. Were auto     | opsy findings                           | available<br>ause of |
| <u>د</u>                   | ysician: The is certificate his director, page   | Con               | Tempemor  | 1 Ro   | and                             | - in  |                     |                      |               | perför<br>1 ☐ Yes          |            | death?             | 2 No                                    |                      |
| Vita                       | ician: Th<br>certificate<br>rector, pag  | Be                | 25. Was case referred to medical examiner?  | Hospital:  |                                 |   | ! Othe              | 00                   |               | Check only or              |            |                    |   |                      |
| of                         | Attending Physician: r death. ector: After this certifics by the funeral director, i   | . To              | 1 Yes 2 No 27. Manner of eath   | 28a. Date of Injur   |                                 |   |                     | 4   1901             |               | 5 Resid                    |            | Other (Special     | fy)                                     |                      |
| on                         | th.<br>: After<br>s tuner  | tlon              | 1 ☐ Natural 5 ☐ Pending<br>2 ☐ Accident investigation   | (Month, Day  |                                 | njury<br>M  | 28c. Injury<br>Work | (?<br>Yes 2 ∐ N      |               |                            | ,          |                    |   |                      |
| Division of Vital Records, | or Attend<br>siter death<br>Director: /  | Certification;    | 3 Suicide 6 Could not be 4 Homicide determined  |  |                                 | rm, street, facto                                 | ry, office          |                      | 28f           | Location (S<br>City or Tow |            | Number or Run      | al Route Num                            | ber,                 |
| _                          | To the Hospital or Attending Ph<br>within 24 hours elter death.<br>To the Funeral Director: Atter th<br>completely filled in by the funeral  | edical Ce         | 29a. Certifier Cartifying Ph  | ysician: To the best of<br>liner: On the basis of                    | of my knowledge                 | , death occurre                                   | d at the tim        | ne, date and         | d place, and  | d due to the c             | ause(s) ar | nd manner as s     | stated.                                 | 3                    |
|                            | the thin 24 the F  | Medi              | one)  29b. Signature and title of coafficer   | and manner sta   | ted.                            |   | oc. License         |                      |               |                            |            | signed (Month,     |   |                      |
| 1                          | ¥ 5 8  |                   | Signature annual of continue  | a M  | 11                              | 2   | 100                 | 27                   | 259           | =                          | The.       | 16                 | 2004                                    | 5                    |
| •                          | 1  |                   | 30. Name and address of person who o  | completed cause of de  | eath (Item 23a) (               | Type, Print)                                      | 9/3                 | 10                   | -30-          | 216                        | /          | R                  |   |                      |
| _                          | 5  |                   | Reserved  | ce 7   | 2//                             |   | 1//                 | Tor                  | 2             | W/                         | 2          | 07                 | 75                                      | per-                 |
|                            | Sta<br>Registi   |                   | 31. Date filed (Month, Day, Year)  JUL 2 1 20   | 32 Registra  | r's Signature                   | porte   |                     |                      |               |                            |            |                    |   |                      |

| Helen Louise Sh  |          | 1- For State<br>Registrar  |  | / Depart<br>Certi  | tment of   | Health and M<br>Death 7/26/  | 06 ЈН   | Reg. No.   | 006 229   |
|--|----------|--|--|--|--|--|---|--|---|
| Physicia<br>Medical Exami  |          | 1. Decedent's Name (First, Middl   |  |  |  |  | 2. Date of I  | Day Year   | 3. Time of Death  |
| *  | 101      | Helen Sheff  4a. Facility Name (if not institution   |  | r)   | - 14   | b. City, Town, or Locat  | July 2, i   | 4c. County o   |   |
|  |          | 18716 Ginger Court   | ·, <b>3</b> ···  | .,   |  | Germantown   |   | Montgom  | nery  |
| Funeral<br>Director  |          | 5. Social Security Number unit 216-72-0224   | 6. Sex 7. A  | ge (In yrs. last   | •  |  | ours Min. Jan   | Birth(MM/DD/YYYY) 3, 1958  | 9. Birthplace (State or unle<br>Foreign <b>West</b><br>Countr <b>Virginia</b>                   |
| any  |          | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, To  | own or Location  | on   |   | · · · · · · · · · · · · · · · · · · ·  | 10d. Inside City Limits   |
| <b>≜</b> .,  |          | MD Monte   | omery  | Ge   | ermanto  | own  |   |  | 1 Yes 2 X No  |
| Aaryland<br>28a-f show<br>3 at once.   | 용        | 10e. Street and Number   |  |  |  | 10f. Zip Code  |   | 10g. Citizen of Wh   | at Country?   |
| th the Maryland<br>23a or 28a-f sho<br>notified at once.   | Director | 18716 Ginger   | Court  |  |  | 20874  |   | USA  |   |
| D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or items 23a or 28a-f shraite event, the Medical Examiner must be notified at once   | Funeral  |  |  |  | If Ye  | s, specify Cuban, Mex  | Origin? ( Specify Yes or ican, Puerto Rican, etc.)  | White  | ,   |
| s after<br>ral",<br>niner  | by       |  | orced If Yes, Give Year<br>or Dates:   |  |  | Yes 2 X No spe   |   |  | white   |
| 2 hours "natur   | ted      | <ol> <li>Decedent's Education (Spe<br/>Elementary/Secondary (0-12)</li> </ol>  | College (1-4 or  |  |  | st of working life. DO N   | ive kind of work donger<br>IOT use retired)   | 16b. Kind of Bus   | siness/Industry <del>unk</del>  |
| 36<br>hin 72<br>e.<br>than<br>sdical   | plet     | unk 10   | unk  |  | Exotic   | Dancer   |   | Entort   | ainment   |
| 21215-0036 uld be filed within 72 Mental Hygiene. marked other than event, the Medical   | Com      | 17. Father's Name (First, Middle   |  |  | LAIOULC  |  | ther's Name (First, Midd  |  |   |
| e file at H fight  | Be (     |  |  |  |  |  | ,   |  |   |
| (  | B        | Kenneth M  | iller  |  |  |  | Freda R   | acknor   |   |
| MD 212<br>12 should b<br>th and Meni<br>17 is marl   | To B     | 19a prormant's Name/Relations 19a C.M.E.   |  |  |  | Temm Scree   | Freda Be<br>Number or Rural Route<br>Rd. Caith<br>t Baltimore   | eckner<br>Number, City or Town<br>Prsburg, Mar<br>1  | <del></del>   |
| re, MD 21215-0036 I and should be filed within 73 Fit eath and Mental Hygiene If riem 77 is marked other than er traumatic event, the Medical  |          | 19a programant's Name/Relations  O.C.M.E.  20a. Method of Disposition  | y (Type, Print )   |  |  | tion (Name of cemeter)   | Freda Be<br>Number or Rural Route<br>Rd. Caith<br>t Baltimore   | eckner<br>Number, City or Town<br>Prsburg, Mar<br>1  | City or Town, State   |
| more, MD 212 Pages 1 and 2 should b rant of Health and Meni<br>ant: If item 27 is marf   |          | 19a programment's Name/Delations  20a Method of Disposition  1 Burial 2 X Cremation  | hip (Type, Print )   | State  | ace of Disposi<br>ematory or oth<br>esapeal  | tion (Name of cemeter)<br>er place)  | Freda Benumber of Rural Route Rd. Carthy Baltimore Date   | Number, City or Towners Dury, March 1997,  | City or Town, State   |
| e, M<br>1 and 2<br>Health :<br>irem 2  |          | 19a programant's Name/Relations  O.C.M.E.  20a. Method of Disposition  | hip (Type, Print)  Removal from Society:   | State  | ace of Disposi<br>ematory or oth<br>esapeal  | tion (Name of cemeter) er place)  Ke Crenator ame any Address of Fa  | Freda Benumber of Rural Route Rd. Gaith Baltimore Date  7 7/26/06   | Peckner Number, City or Love Peckner 20c. Location  Belts Peckner Belts Peckner  | City or Town, State  SVIIIe, Md.  On Scruce   |
| Baltimore, M permit. Pages I and 2 permit. Pages I and 2 pepartment of Health. Important fritem 2 permit.  |          | 19a potermant's Name/Relations  20a. Method of Disposition  1 Burial 2 X Cremation  4 Donation 5 X Oner S  21. Societies Romal  23a. Part I. Enter the disease, or failure. List only one cause  | Removal from S  Decity: IN State  Licensee  Complications that cause on each line.   | Ctor  ed the death. D  | ematory or oth esapeal 2. Na 19.20 Do not enter th   | tion (Name of cemeter, er place)  CE Cremator  ame an, Address of Face mode of dying, such   | Freda Benumber of Rural Route Rd Caith Caith Caith Caith Caith Date  y 7/26/06  Cultiny 19/1201 Clar as cardiac or respiratory  | 20c. Location -  Belts  Cremati  Arrest, shock, or hee   | City or Town, State  SVIIIe, Md.  On Service  |
| Baltimore, M<br>permit. Pages 1 and 2<br>Department of Health<br>Important: fritein 2<br>injury or other traun   |          | 19a beformant's Name/Relations  20a. Method of Disposition  1 Durial 2 X Cremation  4 Donation 5 X Oner S  21. Societies of Funeral Service  Rona  23a. Part I. Enter the disease, or failuse. List only one cause  Immediate Cause (Final disease or condition resulting in death)  | Removal from S  Decity: IN State  Licensee  Complications that cause on each line.   | ctor ed the death. Details the coin a  | ematory or oth esapeal 2. Na 19.20 Do not enter th   | tion (Name of cemeter, er place)  CE Cremator  ame an, Address of Face mode of dying, such   | Freda Benumber of Rural Route Rd Gaith Date  Date  7/26/06  Cliny 100   | 20c. Location -  Belts  Cremati  Arrest, shock, or hee   | City or Town, State  SVIIIe, Md. On Scruce  dd. 21020  — pproximate Interval Between Onset and  |
| Baltimore, M permit. Pages I and 2 permit. Pages I and 2 pepartment of Health. Important fritem 2 permit.  | 10       | 19a programment's Name/Relations  20a. Method of Disposition  1 Burial 2 X Cremation  4 Donation 5 X Oner S  21. Socilare of Funeral errors  23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated   | Removal from S  coecify: in state Licensee Licensee Complications that cause on each line.  Narcotic (1) Due to (or as a condition of the cond | ctor  ctor  ctor  ad the death. E  theroin a  disequence of):  | ace of Disposi<br>ematory or oth<br>esapeal<br>22. N.<br>1921<br>Do not enter the  | tion (Name of cemeter, er place)  CE Cremator  ame an, Address of Face mode of dying, such   | Freda Benumber of Rural Route Rd Caith Caith Caith Caith Caith Date  y 7/26/06  Cultiny 19/1201 Clar as cardiac or respiratory  | 20c. Location -  Belts  Cremati  Arrest, shock, or hee   | City or Town, State  SVIIIe, Md. On Scruce  dd. 21020  — pproximate Interval Between Onset and  |
| ed Ealtimore, M Pernit. Pages I and 2 Department of Health Important fritein 2 injury or other traum   | Examiner | 19a beformant's Name/Relations  20a. Method of Disposition  1  | Removal from S  Decify: IN STATE  Licensee  Complications that cause on each line.  a. Narcotic (I)  Due to (or as a continuous to continuous  | ctor  ctor  ctor  ad the death. E  theroin a  disequence of):  | ace of Disposi<br>ematory or oth<br>esapeal<br>22. N.<br>1921<br>Do not enter the  | tion (Name of cemeter, er place)  CE Cremator  ame an, Address of Face mode of dying, such   | Freda Benumber of Rural Route Rd Caith Caith Caith Caith Caith Date  y 7/26/06  Cultiny 19/1201 Clar as cardiac or respiratory  | 20c. Location -  Belts  Cremati  Arrest, shock, or hee   | City or Town, State  SVIIIe, Md.  On Scruce  dd. 21020  — pproximate Interval Between Onset and |
| executed by Baltimore, M benit. Pages I and 2 Department of Health an and and a benit.   | Examiner | 19a promant's Name/Relations  20a. Method of Disposition  1 Burial 2 X Cremation  4 Donation 5 X Orier S  21. Sou ture of Funeral Service  Rona  23a. Part I. Enter the disease, or failure. List only one cause immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  X UNPENDED | Removal from Society: in state Licensee Complications that cause contact line.  a. Narcotic (1) Due to (or as a contact.) Due to (or as a contact.) Due to (or as a contact.) AMENDED it   | Checked the death. Et al. (Checked the death. Et | ace of Disposi<br>ematory or oth<br>esapeal<br>22. No<br>Do not enter the  | tion (Name of cemeter, er place)  CE Cremator  ame an, Address of Face mode of dying, such   | Freda Benumber of Burle Rough California Date  y 7/26/06  culting one Hone Hone Burle Control and coccurrence | Peckner Number, City or Towar Property Management of the Communication o | City or Town, State  SVIILE, Md.  On Service  14 21020  art Between Onset and Death             |
| Baltimore, M verification of the series of t | 10       | 19a promant's Name/Relations 20a. Method of Disposition 1  | Removal from S  pecify: in state Licensee Complications that cause on each line. Due to (or as a condition) Due to (or as a condition) Due to (or as a condition) AMENDED it  23c. If yes, outcome 1 Live birth  | Checked the death. Et al. (Checked the death. Et | esapeal  22. No position of the sapeal of th | tion (Name of cemeter, er place)  Re Cremator ame an, Address of Farmer and Address of F | Freda Benumber of Burle Rough California Date  y 7/26/06  culting one Hone Hone Burle Control and coccurrence | 20c. Location -  Belts  Cremati  Arrest, shock, or hee   | City or Town, State  SVIILE, Md.  On Struct  21020  pproximate Interval Between Onset and Death |

Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detact á Completed Be Medical Certification: To

cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 1 V Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 examiner? Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 2 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 Natural Pending 1 Yes 2 No Fnd 7/2/2006 Fnd 3:05 pm unk Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 18716 Ginger Court Germantown. MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide 6 X Could not be determined Found at home Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) July 3, 2006

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner

State 31. Date filed (Month, Day, Year) Registrar

3

29b. Signature and title of pertifier

Jack Titus MD.

| Controlled of Death  Special Study Programs of Controlled of Death  As Pathly Passes (Programs of Death Association of Study Programs of Death Association o |          |                                     |       | For State  | State of Maryland / Department of Health and M  | Mental Hygie                              | ene                         | 00007                   |
|--|----------|-------------------------------------|-------|--|---|---|-----------------------------|-------------------------|
| Part      |          |                                     |       | Registrar  | Certificate of Death  | Reg                                       | 1. No. 2 U U 6              | 22931                   |
| Continued to the control of the cont | - 8      | Physic                              | ian   | 1. Decedent's Name (First, Middle, Last)   | 1 Smith   |   | Day Year                    | _                       |
| Subset   Story   Sto   |          |                                     |       | 4a. Facility Name (If not institution, give s  | treet and number   Ab City Town or   And City Town or   | July!                                     | 4,2006                      | 10,274M                 |
| Special South Marshew   Sout   |          | Exami                               | ner   |  |   | ,   | 4c. County of Death         |                         |
| The second of Decision of Second of  | 4        | Funeral                             |       | 5. Social Security Number 6. Sex   | 7. Age (Ip-yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   |   | 9. Birtho                   | place (State or Foreign |
| The part of the pa |          | Director                            |       |  | M 32 F Yrs. Months Days Hours Min.  |   | 1924 Wash                   | 17/1/                   |
| 17. Faithar's Name (First Middle, Last)   17. Faithar's Name (First Middle, Last)   18. Mellytr's Name, (First Middle, Middle, Last)   18. Mellytr's Name, (First Middle, Middle, Last)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Cod   |          | and                                 |       |  | 10c. City. Town or Location   |   |                             | 3                       |
| 17. Faithar's Name (First Middle, Last)   17. Faithar's Name (First Middle, Last)   18. Mellytr's Name, (First Middle, Middle, Last)   18. Mellytr's Name, (First Middle, Middle, Last)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Cod   |          | Maryl<br>-1 sho                     | ğ     | md NI  | a Batt  | 0 )                                       |                             | . /                     |
| 17. Faithar's Name (First Middle, Last)   17. Faithar's Name (First Middle, Last)   18. Mellytr's Name, (First Middle, Middle, Last)   18. Mellytr's Name, (First Middle, Middle, Last)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Cod   |          | r 28a                               | rec   | 10e. Street and Number   | 10f. Zip Code   | 100                                       | Citizen of What Cour        |                         |
| 17. Faithar's Name (First Middle, Last)   17. Faithar's Name (First Middle, Last)   18. Mellytr's Name, (First Middle, Middle, Last)   18. Mellytr's Name, (First Middle, Middle, Last)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Cod   |          | th witi                             | a D   | 4703 fred  | erich Are 21229   |   | 05/                         | 7                       |
| 17. Faithar's Name (First Middle, Last)   17. Faithar's Name (First Middle, Last)   18. Mellytr's Name, (First Middle, Middle, Last)   18. Mellytr's Name, (First Middle, Middle, Last)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Cod   |          | r dea                               | ner   | 11. Maritai Status 1   | 2. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. 14 Yes, specify Cultan Maxican Puerto | ecify Yes or No-                          |                             |                         |
| 17. Faithar's Name (First Middle, Last)   17. Faithar's Name (First Middle, Last)   18. Mellytr's Name, (First Middle, Middle, Last)   18. Mellytr's Name, (First Middle, Middle, Last)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Cod   | 36       | s afte                              |       | . 4  | If Yes, Give 1 Yes 2 No. Specify:   | r riouri, oto.,                           | 0                           | lach                    |
| 17. Faithar's Name (First Middle, Last)   17. Faithar's Name (First Middle, Last)   18. Mellytr's Name, (First Middle, Middle, Last)   18. Mellytr's Name, (First Middle, Middle, Last)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Cod   | 8        | 2 hou                               | ed    | 7  |   | 1.0                                       | 1,0                         |                         |
| 17. Faithar's Name (First Middle, Last)   17. Faithar's Name (First Middle, Last)   18. Mellytr's Name, (First Middle, Middle, Last)   18. Mellytr's Name, (First Middle, Middle, Last)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Code)   19. Melling Address (Sived and Number or Raral Route Number, City or Town, State, 25 Cod   | 215      | hin 7.                              | plet  | (Specify only highest grade  | completed) (Give kind of work done during most of work  | ring                                      | b. Kind of Business/inc     | oustry /                |
| 18. Vallages Name (Final Modifie, Salation Surrane)   19. Vallages (Street and Number or Rural Route Number, City or Town, State, Ze Costs)  | 7        | er tha                              | 5     | 1 Hh   | NIA Homemake  |   | Home                        | OTIC                    |
| Continued at Earth   Continued at Cache   Continued    | nd       | be file<br>id oth<br>sveni          | Be    | 17. Father's Name (First, Middle, Last)  | 18. Mother's Name   | e (First, Middle, Ma                      | iden Sumame)                | 26                      |
| Continued at Earth   Continued at Cache   Continued    | <u>Ş</u> | 3 Men<br>marke                      | မ     | Joseph   |   |   | - 1501                      | mes                     |
| Continued at Earth   Continued at Cache   Continued    | Ma       | d 2 sl<br>th an<br>t7 is r<br>traur |       |  | theyhar   |   |                             |                         |
| Continued at Earth   Continued at Cache   Continued    |          | Heal<br>Heal<br>tem 2               |       | 20a. Method of Disposition   | 20b. Place of Disposition (Name of  |   |                             |                         |
| 23. Part Name of the Sease, or femiciations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Physician   Medical Examining   Medical Exami | - E      | a 0                                 |       | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  | moval from State cemetery, crematory or other place)  |   | 1                           |                         |
| 23. Part Name of the Sease, or femiciations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Physician   Medical Examining   Medical Exami | alti     | mit. I<br>partm<br>portar<br>/ inju |       |  |   |   |                             |                         |
| Physician / Medical Examiner  Physic | m        | P 9 F 9                             |       | South 1 War  | Corres e nounds to  |   |                             |                         |
| Prysician   Medical Examiner     |          |                                     |       | 23a. Part1 Enter the trisease, or complications shock, or heart failure. List only one | ations that caused the death. Do not enter the mode of dying, such as cardiac cause on each line.                           | or respiratory arrest,                    |                             |                         |
| Southerful reading of the search of the sear |          |                                     |       | Immediate Cause (Final disease or condition  |   |   |                             | Onset and Death         |
| Sequentially list conditions.  Sequential list conditions.  Se |          |                                     |       | resulting in death)  |   |   |                             | o mus                   |
| Cause (Disease of righty)  Due to (or as a consequence of):  d.  Due t |          |                                     | - E   | Sequentially list conditions, b.   |   |   |                             | YRS.                    |
| State   Stat   | _        | uted Insit                          | mlne  | cause. Enter Underlying Cause (Disease or injury                                       | 1 + 11 1-   |   |                             | V                       |
| State   Stat   | Ć        | execu<br>in and                     | Exa   | resulting in death) Last   | 3,000   |   |                             | 700-                    |
| FFEMALE   23b. Was decodent pregnant   1   Live bith 2   Felal death 3   Ectopic pregnancy   23d. Date of delivery   Month Day Year   23d. Date of Date    | 176      | ite be<br>lysicia<br>ne bur         | cal   | C d.   |   |   |                             |                         |
| 24a. Was an autopsy performed to completion of cause of death   24b. Were autopsy performed      | 9        | artifica<br>ing ph<br>e as th       | Med   | IF FEMALE:   |   |   |                             |                         |
| 24a. Was an autopsy performed to completion of cause of death   24b. Were autopsy performed      | 80       | ath ce                              | lan/  | 23b. Was decedent pregnant 23c   | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  |   |                             | •                       |
| 24a. Was an autopsy performed to completion of cause of death   24b. Were autopsy performed      |          | he de<br>the a                      | ysic  | 1 ☐ Yes 2 🛣 No   |   |   | Month                       | Day Year                |
| 24a. Was an autopsy performed to completion of cause of death   24b. Were autopsy performed      |          | that the by detact                  | H.    | Part II. Other significant conditions contr  | ibuting to death but not resulting in the underlying cause given in Part to   | 23e Did tobaco                            | CO LIEG CORTUDIATO TO The   | 2 course of death?      |
| 24a. Was an autopsy performed to completion of cause of death   24b. Were autopsy performed      | ds       | puires<br>n sign<br>ald be          | d b   | CHF, CVA   | - D 1 ( - 1 - 1 + 1   |   |                             |                         |
| 26. Place of Death (Check only one)  26. Place of Death (Check only one)  27. Manner of Death 1   Yes   Ze   No  28. Describe how injury occurred  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Death (Check only one)  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Injury at Work?  29. Location (Street and Number or Rural Route Number.  29. City or Town, State)  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury o | 00       | s beer                              | lete  | alexal alline  | m 5.  |   |                             | /                       |
| 26. Place of Death (Check only one)  26. Place of Death (Check only one)  27. Manner of Death 1   Yes   Ze   No  28. Describe how injury occurred  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Death (Check only one)  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Injury at Work?  1   Yes   2   No  28. Place of Injury at Work?  29. Location (Street and Number or Rural Route Number.  29. City or Town, State)  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury occurred  29. Describe how injury o | Re       | The la                              | E     | 8 2000   |   | autopsy<br>performed                      | ? prior to com<br>death?    | ptetion of cause of     |
| 30. Name and address of person who completed causal of death (Item 23a) (Type, Print)  Michael G. Hayles; 827 Linden Ave., Belto 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  | ita      | ian:<br>rtifica<br>ctor, p          |       | 25. Was case referred to medical   | 26. Place of Death  |   | No 1 Yes 2                  | 253 No                  |
| 30. Name and address of person who completed causal of death (Item 23a) (Type, Print)  Michael G. Hayles; 827 Linden Ave., Belto 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  | × ×      | hysic<br>his ce                     | 2     | 1 ☐ Yes 25 No  | spitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor  |   | 6 SOther (Specify)          | HOSPICE                 |
| 30. Name and address of person who completed causal of death (Item 23a) (Type, Print)  Michael G. Hayles; 827 Linden Ave., Belto 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  | N C      | ling P                              | ion:  |  |   | 28d. Describe how in                      | njury occurred              | .,,                     |
| 30. Name and address of person who completed causal of death (Item 23a) (Type, Print)  Michael G. Hayles; 827 Linden Ave., Belto 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  | isio     | death<br>death<br>stor: ,<br>the f  | icat  | 3 Suiside 6 Could not be   |   |   |                             |                         |
| 30. Name and address of person who completed causal of death (Item 23a) (Type, Print)  Michael G. Hayles; 827 Linden Ave., Belto 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  | Ď        | lor A<br>after<br>Direct<br>In by   | ertif |  | 289. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                      | 28f. Location (Street<br>City or Town, St | and Number or Rural<br>ate) | Route Number,           |
| 30. Name and address of person who completed causal of death (Item 23a) (Type, Print)  Michael G. Hayles; 827 Linden Ave., Belto 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  |          | spita<br>nours<br>neral             | alc   | 29a. Certifier 1- Certifying Physic  | ian: To the best of my knowledge, death occurred at the time, date and place, a   | and due to the cause                      | (s) and mannor as sto       | tod                     |
| 30. Name and address of person who completed causal of death (Item 23a) (Type, Print)  Michael G. Hayles; 827 Linden Ave., Belto 21201  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  |          | n 24 h                              | edic  | (Check only 2 Medical Examine one)   | . On the basis of examination and/or investigation, in my onlinion, death occurre   | ed at the time, date a                    | and place, and due to t     | the cause(s)            |
| State 31. Date filed (Month, Day, Year) 32 Registrar's Signature   |          | To t<br>To t                        | Σ     | 29b. Signature and title of certifier  | . /   |   |                             | ay, Year)               |
| State 31. Date filed (Month, Day, Year) 32 Registrar's Signature   | •        | 1                                   |       | > Whichart 5   | - Hayes, MD 2000 2290   | 0   | 7/17/06                     |                         |
| State 31. Date filed (Month, Day, Year) 32 Registrar's Signature   |          | 5                                   |       |  | oleted cause of death (Item 23a) (Type, Print)  | 12.0                                      | ,                           |                         |
| Giate  | 25       |                                     |       | 110.000  |   | 0 2120                                    | /                           |                         |
|  |          |                                     |       | JUL 2 1 2006   | Release H. Acad .   |   |                             |                         |

22938 State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 12:55 PM CHARLES JULY SCHAA F 13 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTEHORE HARBOR HOSPITAL Baltimore County If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) 06/17/1923 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours 1⊠M 2□F Yrs Director 215-18-8860 Maryland 83 Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
The and Te marked other than "natural; or Items 23a or 28a-1 show other resumatic event, the Medical Exteriform and the notified at 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Baltimore County 1913 Casadel Avenue, Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21230 1913 Casadel Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Linesman/Electrical Electrical N/A 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be William John Schaaf Elizabeth Seimer ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn S. Schaaf (Wife) 1913 Casadel Avenue, Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h int: If ite 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ortant: If 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery 07/22/2006 Baltimore, Maryland 21. Signature of Pure al Service Licensee Deportr Deportr Importu any nji 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ARRHYTHMIA disease or condition resulting in death) 5 MINUTES /Medical Due to (or as a consequence of) Examiner 12 DAYS PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner COPD - CHRONIC OBSTRUCTIVE PULMONARY DISEASE physicien and s the burial-transit 30 YEARS Due to (or as a consequence of): Physician/Medical UNCERTAIN CARDIOMYOPATHY attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 □ No 3 Probably 4 Unknown AORTIC ANEURYSM ABOOHINAL Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 sl 24a. Was an 1 ☐ Yes 2 No 2 1 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA this To the Hospital or Attending Pr within 24 hours after death. To the Funerel Director: After the Completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. Front By RES000 JULY 18 - 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300: SOUTH HANOUER ST, BALTEMORE, MD, 21225 FRANCUIS GREGUERE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 2 1 2006 1024 Registrar

Division of Vital Records, P.O. Box 68760

06-05192 Clifton T. Sechrist

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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| ž |    |     | 10 | *** | b | 20.0 | 0  | es. |

|   |                | 1- For State Certificate of Registrar Certificate of Registrar  | f Death   | Reg. No. 2005 2293  |
|---|----------------|---|---|---|
| Physicia<br>edical Exami  |                | Decedent's Name (First, Middle,Last)     CLIFTON T. SECHRI  | 2. Date of Do Month July 18,  | Day Year  |
|   |                | 4a. Facility Name (if not institution, give street and number) Sinai Hospital   | 4b. City, Town, or Location of Death  Baltimore   | 4c. County of Death N/A   |
| Funeral<br>Director   |                | 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 78 Yrs   | Months Days Hours Min. 05-1   | 9-1928 Foreign Country, ARYLAND   |
| tth the Maryland<br>23a or 28a-f show any<br>notified at once.  | tor            | Usual Residence of Decedent  10a State  | LUTHERVILLE   | 10d. Inside City Limits 1 Yes 2XX No  |
| the Mar<br>3a or 28a  | Director       | 6 NIGHTINGALE WAY, APT. A-3   | 10f. Zip Code 21093   | 10g. Citizen of What Country? U.S.A.  |
| ter death w   | by Funeral     | Never Married 2 Married XX Yes 2 No If Y Yes 2 No If Yes (Ive Year 1946-1947 or Dates:  | is Decedent of Hispanic Origin? (Specify Yes or res, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2XX No specify:  It's Usual Occupation (Give kind of work done) | No- 14. Race - American Indian, Black, White, etc. WHITE Specify:  16b. Kind of Business/Industry |
| 11215-0036 Id be filed within 72 hours af Jental Hygiene. arked other than "matural event, the Medical Examin   | Completed      | Elementary/Secondary (0-12) College (1-4 or 5+) MAC   | ost of working life. DO NOT use retired)  CHINIST   | MACHINE SHOP  |
| 215-0<br>be filed w<br>ntal Hygid<br>rked othe<br>ent, the N  | Be Co          | 17. Father's Name (First, Middle, Last)  JOSEPH HARVEY SECHRIST   | 18.Mother's Name (First, Middle JUANITA V.  |   |
| MD 21 ad 2 should the and Mer n 27 is mar   | To             | 19a. Informant's Name/Relationship (Type, Print ) HAZEL NORMENT (FRIEND) 19b. Mailing   | GADRIES (Street and Number or Rural Route N<br>GHTINGALE WAY, APT.A-3,  | umber, City or Town, State, Zip Code) LUTHERVILLE, MD.21093                                       |
| = 20 0  |                | 1 Burial 2 XX Cremation 3 Removal from State HILLTOP S  4 Donation 5 Other Specify:   | ERVICE CORP. 07-21-200  |   |
| Balt<br>permit<br>Departi<br>Import   |                | K. J. Ro (R.G.RUTH) RU  | Name and Address of Facility  CK TOWSON FUNERAL HOME  | 1000001,110.21201   |
| Physician<br>/Medical<br>Examiner   |                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  | he mode of dying, such as cardiac or respiratory a  | Approximate Interval Between Onset and Death  |
|   | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  |   |   |
| ited<br>d<br>ansit  | Examine        | (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):   |   |   |
| 760,<br>icate be executed<br>physician and<br>the burial - transit  | Medical        | UNPENDED AMENDED  |   |   |
| Division of Vital Records, P.O. Box 68760, within 24 hours after detailing Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transitions. | sician/        | past 12 months:   | tal death 3 Ectopic pregnancy her (Specify)   | 23d. Date of delivery  Month Day Year   |
| P.O. E es that the cigned by the detached   | by Phy         | Part II. Other significant conditions contributing to death but not resulting in the u  |   | tobacco use contribute to the cause of death?   |
| Vital Records, P.C hysician: The law requires that this certificate has been signed I director, page 2 should be deta   | Completed      |   | 24a. Wa   | s an 24b Were autopsy findings available prior to completion of cause of death?                   |
| Vital Rechysician: The lithis certificate   | Be             | 25. Was case referred to medical examiner?  1   | 26.Place of Death (Check only one)  | Residence 6 Other:  |
| ion of V<br>tending Phys<br>teath.<br>tor: After thi  | ation: To      | 1 ✓ Yes 2 No The impatient 2 ✓ ENVOURAITENT 2 V ENVOURAI | njury 28c. Injury at Work? 28d. Describe  | e how injury occurred o auto collision  |
| Division  To the Hospital or Attendir within 24 hours after death.  To the Funeral Director: A completely filled in by the fu   | Certification: | 3 Suicide 6 Could not be determined (Specify) Local Street  | or Town,  | (Street and Number or Rural Route Number, City<br>State)<br>I & Woodward Lane, Lutherville, MD    |
| To the Hosy<br>within 24 ho<br>To the Fun<br>completely f   | edical (       | 29a Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occur one) Physician: To the basis of examination and/or investigat and manner stated.  |   |   |
| £ 3 £ 8   | Me             | 29b. Signature and title of certifier  Mana Brassell MD.  | 29c. License number O.C.M.E.  | 29d Date signed (Month, Day, Year)  July 19, 2006   |
| 44  |                | Name and address of person who completed cause of death (Item 23a)     Melissa Brassell, MD   | Penn Street, Baltimore, MD 21201  |   |
| S<br>Regis  | tate<br>trar   | 1111 0 4 2000 1 6 1 1   | uli   |   |
| DHMH 17 Rev 1/2   | 2001           | ORIGINA   | L   |   |

**Physician** /Medical **Examiner** 

**Funeral Director** 

Director

Completed by Funeral

Be

2

or 28a-f show "naturel", or Items 23a

Raymond Smith

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examiner must be notified at Is marked other than 2 should be filed with and Mental Hygiene, nt of Health : permit. Page Department of Important: If any injury or

**Physician** /Medical Examiner

burial-transit the death. al or Attend after death Director: To the Hospitel o within 24 hours af To the Funerel D

Box 68760

P.0.

Division of Vital Records,

Examiner Physician/Medical ģ Completed Be

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Center Randallstown Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 17,1925 5. Social Security Number 296-16-6833 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Sex XXM 2□F Õhio 81 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes XXNo Owings Mills MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4502 Brightwater Court 21117 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. XIXYes 2 □ No If Yes, Give WW II Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 CNo Specify: Specify: XXWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Conductor 12 Railroad 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Stanley Smith Lucina Giles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Smith/Daughter 57 Jessica Court; Little Canada, MN. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cometery, cromatory or other place)
Quantico
National Cemetery 7/20/06 XXBurial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) Quantico, VA. 21. Signature d'uneral Jervice License 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TEMMINAL ASPINATION PNEUMONIA Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23d, Date of delivery

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death

4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

Month Dav

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LATE EFFECT STROILE DIABLECES MEZLITUS

CIMOMIC OSSTRUCTIVE PULM DISTAGE

24a. Was an autopsy performe 2 No 1 ☐ Yes 26. Place of Death (Check only one,

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Year

25. Was case referred to medical examiner? 1 Tyes 2. No

5 Pending investigation 6 Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work?

1 🔽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

PANDAZLS TOWN, MD

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

27. Manger of Death

1 Natural

3 Suicide

29a, Certifie

2 Accident

29c. License number H45931

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daparah T YLG 31. Date filed (Month, Day, Year) JUL 2 1 2006

5401 32 Registrar's Signature Secre-

OLD COURT ROAD mele

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1, perMD 9857, 7/21/06 TT
State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health and Mental Hygiene On the State of Maryland Department of Health Andrew Department of Health Andr

|   | -             | For State Of Wall   | -                                  | rtificate of De  |                                     |  | . No.                                       | 22941  |
|---|---------------|---|------------------------------------|--|-------------------------------------|--|---|--|
| Physicia  | an            | 1. Decedent's Name (First, Middle, Last) Clyde  | J. Truluck                         | 3  |                                     | 2. Date of Death<br>Month                  | Day Year                                    | 3. Time of Death                                   |
| /Medic<br>Examin  | al            | 4a. Facility Name (If not institution, give street and number)  | LOCE                               | 4b. City, Town, or Loc   | cation of Death                     | 7007                                       | 4c. County of Deal                          | 0 3  |
|   | 2             | 2/0   | SPITAL                             | BALTIM (   | ORE  <br>Under 24 Hrs.              | MD   | BALTIM                                      | ORE CITY   |
| Funeral<br>Director   | -             | 257-38-4311 1DM 20F   | (In yrs. last birthday,<br>14 Yrs. |  | lours Min.                          | 8. Date of Birth<br>(Month, Day, Y         | (ear) Co                                    | hplace (State or Foreign<br>untry)<br>UTGLA        |
| yland   |               |   | 10c. City, Town or L               | ocation  |                                     |  |   | 10d. Inside City Limits                            |
| Ba-fah  | Director      | Maryland Baltimore  |                                    | Perry Hal  | 'L                                  |  |   | 1 □Yes 2X No                                       |
| pormit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avent, the Madical Examities must be notified at once. | al Dire       | 10e. Street and Number<br>9604 M Haven Farm Road  |                                    | 10f. Zip Code  | 21128                               |  | u.S.A.                                      | untry?   |
| items   | Funeral       | 11. Marital Status 12. Was Decedent Ev<br>Armed Forces?<br>1 □ Never Married 2 Married 1 2 Yes 2 □ No                         | ver in U.S. 13.                    | Was Decedent of Hispa<br>If Yes, specify Cuban, N                              | nic Origin? (Spe<br>Mexican, Puerto | acify Yes or No-<br>Rican, etc.)           | 14. Race - Ame<br>Black, Whit               |  |
| ours aft  | þ             | 3 Widowed 4 Divorced Year or Dates:   |                                    | 1 ☐ Yes 2 X No S   | Specify:                            |  | Specify: (                                  | 1hite  |
| "natur  | Completed     | 15. Decedent's Education (Specify only highest grade completed)   | (Give                              | ident's Usual Occupation<br>is kind of work done during<br>DO NOT use retired) | n<br>ng most of worki               |  | S. Air Fo                                   |  |
| y withir jiene.   | omo           | Elementary/Secondary (0-12) College (1-4or 5+   | )                                  | hnical Serg  | eant                                |  | edical Cer                                  |  |
| be filed<br>tal Hyg<br>d othe   | BeC           | 17. Father's Name (First, Middle, Last)   |                                    |  |                                     | (First, Middle, Ma                         |   |  |
| ial y latter A. I.A. 2 should be filed withing and Mental Hygiene. Is marked other than surnetic event, Iran  | ဥ             | Clyde Mack Truluck  19a. Informant's Name/Relationship (Type, Print)  | 19b Mail                           | ing Address (Street and  | Nettie<br>Number or Bura            |  | CIYLOR City or Town State                   | Zip Code)  |
| nnd 2 s<br>alth an<br>27 is<br>ar trau  |               | Clyde R. Truluck (son)  |                                    | Delafield C  |                                     |  | -   |  |
| Pages 1 and nent of Health nt: if Item 27 iry or other tr   |               | 20a. Method of Disposition 1 🗷 Burial 2 🗀 Cremation 3 🗀 Removal from State  |                                    | matory or other place)   |                                     |  | c. Location - City or                       |  |
| iit. Pa<br>artmen<br>ortant:<br>injury  |               | 4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  | St. Jose                           | ph Ch. Cem. 2. Name and Address of   | Facility Sch                        | imunah Fu                                  | illerton,                                   | Maryland   |
| permit. Departr Imports any inje  |               | Burn G. Willer  |                                    | 705 Belair 1   |                                     |  |   | 163  |
| 2   |               | 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line     | he death. Do not er                | ter the mode of dying, su  | uch as cardiac c                    | or respiratory arres                       | t,  | Approximate<br>Interval Between<br>Onset and Death |
| Physician<br>/Medical   |               | Immediate Cause (Final disease or condition resulting in death)   | 515                                |  |                                     |  |   | Chisel and Death                                   |
| Examiner  |               | ASP   | IRATION                            | PNEU   | MONIK                               | 1  |   |  |
| pe tis  | iner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                   | consequence of):                   |  |                                     |  |   |  |
| n and al-tran   | Examiner      | that initiated events C.  | consequence of):                   |  |                                     |  |   |  |
| gol Co,   | Medical       | d   |                                    |  |                                     |  |   |  |
| Sertifica<br>ding pl  |               | IF FEMALE: 23c. If yes, outcome of  | foregnancy                         |  |                                     |  | 23d. Date of del                            | ivon.  |
| death death of for u  | Physician/I   | in the past 12 months?  1 Vas 2 No  1 Vas 2 No  | Fetal death 3                      | □Ectopic pregnancy<br>□ Other (specify)  |                                     |  | Month                                       | Day Year   |
| v requires that the death cer<br>been signed by the ettendir<br>should be detached for use  | Phys          | 9 ☐ Unknown   | not regulting in the               | radash in a navan awan in  | n Dart I                            | 230 Did toba                               | occurs contribute to                        | the cause of death?                                |
| requires the  | d by          | Part II. Other significant conditions contributing to death but $DEMENTIA$  | not resulting in the               | anderlying cause given in  | n Parti.                            |  |   | obably 4 Wunknown                                  |
| aw requir   | Completed     |   |                                    |  |                                     | 24a. Was an                                | 24b. Were au                                | topsy findings available                           |
| VICAL DESIGNATION OF THE PASS CONTINUES HAS RECTOR, PAGE 2  | Com           |   |                                    |  |                                     | autopsy<br>performe<br>1 Yes 2             | d? death?<br>☐ No 1 ☐ Yes                   | completion of cause of<br>2 No                     |
| JII OI VILAI INCE<br>Jing Physician: The lav<br>After this certificate has<br>funeral director, page 2  | o Be          | 25. Was case referred to medicat examiner?  1 Yes 2 No Hospital: 1 Inpatient  | t 2 ER/Outpatie                    | Other  |                                     | (Check only one)                           | ce 6 □Other (Spe                            |  |
| ding Phys   | on: To        | 27. Manner of Death 1 Natural 5 Pending (Month, Day   |                                    |  |                                     | 28d. Describe how                          |   | siy)   |
| Store<br>the function<br>the function   | catic         | 2 Accident investigation  |                                    | M 1 Yes  | 2 □ No                              | OBE Location (Stro                         | et and Number or Ri                         | ural Pauta Number                                  |
| al or Ai<br>s efter<br>if Direct  | Certification | 4 Homicide determined building, etc.  | y - At home, farm, s<br>(Specity)  | теет, тастогу, оптсе   |                                     | City or Town,                              |   | irai noute ivamber,                                |
| To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours later death.  To the Funeral bifactor: Attenting certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit           | Medical (     | 29a. Certifier 1 Certifying Physician: To the best of (Check only one) 1 Medical Exeminer: On the basis of earth manner state | examination and/or in              | th occurred at the time, onvestigation, in my opinion                          | date and place,<br>on, death occurr | and due to the cau<br>ed at the time, date | se(s) and manner as<br>a and place, and due | stated.<br>to the cause(s)                         |
| To the<br>Within<br>To the  | ₩             | 29b. Signature and title of certifier   | 4. 4                               | 29c. License nu  |                                     |  | I. Date signed (Mont                        |  |
| 104   |               | Hebert Keedman !  | 20.                                | 019  | 306                                 | 1  | aly 15                                      | 2006   |
| 1001  |               | 30. Name and address of person who completed cause of dea HELBERT FRUTOMAN M.   | ath (Item 23a) (Type               | D19,<br>LOCH RAI   | VEN BC                              | LD RA                                      | TIMORS                                      | 2006<br>MD 21239                                   |
| Sta   |               | · ·   | 's Signature                       |  |                                     | 1  | - ///                                       |  |
| Registr   | ar            | 2 1 2006  | & be                               | 100  |                                     |  |   |  |

4 TUREMAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🛭 🗎 💍 1 - For Stata Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 7:20 M George Tureman 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GlenBurne
If Under 1 Year If Under 24 Hrs. Bit: me Wishington Medical
5. Social Security Number 6. Sex 7. Age Center 8. Date of Birth (Month, Day, Year) Anne Arundel 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 M 2□ F Days 224-38-2322 72 Yrs Director Virginia Usual Residence of Decedent Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits Directo 1 Yes 2 No Maryland Millersville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8245 Woods Road 21108 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰76s 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)
N/A 12 Chief Warran Officer U.S. Coast Guard traumatic avent. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tureman Aubry Mamie Staton ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Tureman (Son) 8245 Woods Road Millersville Maryland 21108 Item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages nent of h Depertment of Important: If It any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville V.A. Cem. 7/21/06 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland 21. Signature of Fungital Service Licensee Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part1 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) neumon 2 weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, faul cause. Enter Underlying Cause (Disease or injury Dileito (Gras siconsequence of) Examine certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death? certificete has 1 ☐ Yes 2 ☐ No of Vital After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1- Impatient 2 ER/Outpatient 3□ DOA 28b. Time of Injury 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation death. I Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the "uneral Direct 4 Homicide ŏ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Tu MI 24781 wilos 111 141) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles leu 6 sultive e Medical BUTHLE worth enter 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUL 2 1 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2000 6

|          |  |                | 1 - For<br>State<br>Registrar   |                                 | State of Ma  | aryland .                 |                              | iriment of t<br>tificate of            |                               | ina Menta                         |                                   | ienę    <br>eg. No.              | Ub                     | 44                    | J4 J       |
|----------|--|----------------|---|---------------------------------|--|---------------------------|------------------------------|--|-------------------------------|-----------------------------------|-----------------------------------|----------------------------------|------------------------|-----------------------|------------|
| H        | Physici  | an             | Decedent's Name (Fire   |                                 | st)  | -                         |                              |  |                               |                                   | te of Dear                        | th<br>Day                        | Year                   | 3. Time of            | Death      |
|          | /Medi  |                | Clifton T   |                                 |  |                           |                              |  |                               | 10                                | 44                                | 14, 2                            | 906                    | god                   | PM         |
|          | Examir   | er             | 4a. Facility Name (If not   | institution, give               | street and number)   | Maca                      | 60                           | 4b. City, Town,                        | 2250                          | f Death                           | y                                 | 4c. County                       | of Death               |                       | •          |
|          |  |                | 5. Social Security Number   | er 6. S                         | METAL M  | (In yrs. last             | highday                      | If Under 1 Year                        | If Under 2                    | A Hrs In The                      | a of Diah                         |                                  | 0.0:4                  |                       |            |
|          | Funeral<br>Director  |                | 220-78-672  | 7                               | M 2□ F   | 44                        | Yrs.                         | Months Days                            |                               | Min. (Me                          | te of Birth<br>onth, Day,<br>t 13 | Year)<br>1961                    | 9. Birthp              | place (State ontry)   | unk<br>    |
|          | and w  |                | Usual Residence of Deci<br>10a. State 10b                                     | . County                        |  | 10c. City, T              | own or Loc                   | ation                                  |                               |                                   |                                   |                                  | 1                      | 0d. Inside C          | ity Limits |
|          | Maryl<br>f sho   | ō              | MD  |                                 |  | Po1+                      | imore                        |  |                               |                                   |                                   |                                  |                        |                       | 2 No       |
|          | 28a  | Director       | 10e. Street and Number  |                                 |  | рать                      | TINOLE                       | 10f. Zip Code                          |                               |                                   | 1                                 | 0g. Citizen of                   | What Cour              |                       |            |
|          | ter death with the Marylan<br>Items 23a or 28a-f show<br>Institutet be notified at   | <u></u>        | 1217 W. Fa  | yette S                         | Street   |                           |                              |  | 1223                          |                                   |                                   | US                               |                        | , .                   |            |
|          | deat   | Funeral        | 11. Marital Status  | unk                             | 12. Was Decedent E<br>Armed Forces?  | ver in U.S.U              | ınk 13. y                    | as Decedent of                         | Hispanic Orig                 | in? (Specify Ye                   | s or No-                          |                                  | e - Americ             |                       |            |
| 5-0036   | hours after death with the Maryland<br>ural', or Items 23a or 28a-f show<br>Il Exercities front be notified at   | by             | 1 Never Married 3 Widowed 4 1   | _                               | 1 Yes 2 N<br>If Yes, Give<br>Year or Dates:  | lo                        |                              | Yes, specify Cut                       |                               | Puerto Hican,                     | etc.)                             |                                  | ck, White,<br>y: bla   |                       |            |
| 2        |  | Completed      | 15. I   | Decedent's Ed                   | lucation   | 1                         | 6a. Deced                    | ent's Usual Occu                       | pation                        | -d                                | ınk                               | 16b. Kind of B                   | usiness/In             | dustry                | unk        |
| 7        | within 72<br>ene.<br>then "na  | nple           | Elementary/Secondary  |                                 | College (1-4or 5   | +)                        | life. D                      | aind of work done ONOT use retire      | auring most<br>ad)            | or working                        |                                   |                                  |                        |                       |            |
| 7        | filed wi<br>Hygien<br>ther th  | Con            | unk   |                                 | ınk  |                           |                              | unt.                                   |                               |                                   |                                   |                                  |                        |                       | unk        |
| /land    | a la p 💆   | Be             | 17. Father's Name (First,   | Middle, Last)                   |  |                           |                              | unk                                    | 18. Mother                    | 's Name (First,                   | Middle, N                         | Maiden Suman                     | ne)                    |                       | unk        |
| _        | should<br>nd Men<br>marke<br>umatic  | To             | 10 1/2 1/2  |                                 |  |                           | d 1. a.:                     |  |                               |                                   |                                   |                                  |                        |                       |            |
| <u>8</u> | d 2 st<br>th and<br>7 Is n<br>treun  |                | 19a. Informant's Name/F   |                                 |  | 1                         |                              | Address (Street                        |                               |                                   |                                   |                                  |                        | Code)                 |            |
| e)       | 1 and<br>Heelth<br>em 27<br>ither ti   |                | Maryland Ge 20a. Method of Disposition  |                                 | поѕрттат   | 20b. Place                |                              | Linden A                               | venue                         | Date                              |                                   | MD 212<br>20c. Location -        |                        | un Ctata              |            |
| Ē        | nit. Pages 1 and 2 should<br>entment of Heelth and Men<br>ortant: If item 27 is marke<br>Injury or other trsumatic<br>8.   |                | 1 ☐ Burial 2 ☐ Cre  | emation 3 🗆                     | Removal from State  in state   | ceme                      | etery, crem                  | atory or other pla                     | се)                           | Date                              | Í                                 | eoc. Location -                  | City or To             | wn, State             |            |
| ng<br>Da | Depermit<br>Deperment<br>Import<br>eny in  |                | 21. Signature of Uneral<br>Rona   | Service Licen:                  | Wade Nine  | gtor                      |                              | Name and Addit<br>1 timore,            |                               | oard 655<br>21201                 | 5 W.                              | Baltim                           | ore S                  | treet                 |            |
|          |  |                | 23a. Part1. Enter the dis   | sease, or comp                  | blications that caused one cause on each line  | the death. D              | o not ente                   | r the mode of dyi                      |                               |                                   | atory arre                        | est,                             |                        | Approximate           |            |
|          | Physician  |                | Immediate Cause (Final disease or condition                                   |                                 | DoohiN   | hmi                       | 2                            |  |                               |                                   |                                   |                                  |                        | Onset and (           |            |
|          | /Medical   |                | resulting in death)   |                                 | Due to ter as a  | consequence               | ce of):                      | 1 -                                    |                               |                                   |                                   |                                  |                        |                       |            |
|          | Examiner   |                | Sequentially list condition   | ns                              | , XLUPER   | Kali                      | emic                         | 2/Ac                                   | rdos                          | 13                                |                                   |                                  |                        |                       |            |
| -        | D #  | Examiner       | Sequentially list condition if any, leading to immedicause. Enter Underlying  | ate                             | Dure to (or as a   | consequence               | ce-of)                       |  | idos<br>Isea                  |                                   |                                   |                                  |                        |                       |            |
|          | ecute<br>and<br>trans  | cam            | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last | 1                               | EM JY  | age                       | Ben                          | al &                                   | isla                          | se                                |                                   |                                  |                        |                       |            |
| ລົ       | cien s   | E              | Todamiy iii doda, j dada  |                                 | Due to (or as a  | consequenc                | ce of):                      |  |                               |                                   |                                   |                                  |                        |                       |            |
| 00/00    | tificate be executed to physicien and as the burial-transit  | edical         |   | •                               | d  | -                         |                              |  |                               |                                   |                                   |                                  |                        |                       |            |
| X        | ± on e   |                | IF FEMALE:  |                                 | 23c. If yes, outcome of  | of pregnancy              |                              |  |                               |                                   |                                   |                                  |                        |                       | *          |
|          | atten<br>I for u   | Physician/N    | 23b. Was decedent preg<br>in the past 12 month                                | mani                            | 1 ☐ Live birth 2<br>4 ☐ Pregnant at t  | Fetal dea                 |                              | Ectopic pregnanc<br>Other (specify)    | /                             |                                   |                                   | 23d. Dat                         | le of delive<br>nth    |                       | 'ear       |
| į        | the d<br>y the<br>ached  | lys            | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   |                                 | 9□ Unknown   |                           | ,                            | outor (specify) _                      |                               |                                   |                                   |                                  |                        |                       |            |
| Ţ        | s that   | by P           | Part II. Other significant  | conditions co                   | entributing to death bu  | t not resulting           | g in the und                 | derlying cause giv                     | ren in Part I.                | 23                                | e. Did tob                        | acco use conti                   | ribute to th           | e cause of d          | eath?      |
| ,<br>SD  | tending Physician: The law requires that the death centeath.   |                |   |                                 |  |                           |                              |  |                               |                                   | 1 🗌 Ye                            | s 2 No                           | 3 Proba                | ably 4                | Inknown    |
| 2        | s bee  | Set            |   |                                 |  |                           |                              |  |                               | 24:                               | a. Was an                         | 24b. V                           | Vere autor             | sy findings a         | available  |
| ב        | The it   | Completed      |   |                                 |  |                           |                              |  |                               | _                                 | autopsy<br>perform                | ед                               | prior to con<br>leath? | npletion of ca        | use of     |
| 9        | an:<br>rtifice<br>tor, p   | 0              | 25. Was case referred to  | medical                         |  |                           |                              |  | 26 Place o                    | of Death (Check                   | Yes 2                             |                                  | ☐ Yes                  | 2∐ No                 |            |
| >        | ls ce<br>direc   | To B           | examiner?   |                                 | Hospital: 1 Inpatien   | t 2 ER/0                  | Outpatient                   | 3□ DOA Ott                             |                               | sing Home 5[                      |                                   |                                  | er (Specify            | }                     |            |
| <b>O</b> | ng Ph<br>ter th<br>neral   |                | 27. Manner of Death 1 ☑Natural 5 □  | 7 Deadine                       | 28a. Date of Injury<br>(Month, Day   | Year) 28b                 | . Time of<br>Injury          | 28c. Injur                             |                               |                                   |                                   | w injury occurr                  |                        | <u></u>               |            |
| 2        | endir<br>path.<br>pr: A  | atlo           | 2 Accident  | Pending<br>investigation        | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  |                           | quiy                         |  | Yes 2 □No                     | 0                                 |                                   |                                  |                        |                       |            |
| <u> </u> | at or Att<br>after de<br>Direct<br>d in by t   | Certification: | 3 ☐ Suicide 6 ☐<br>4 ☐ Homicide   | Could not be determined         | 28e. Place of Injur<br>building, etc.  | y - At home,<br>(Specify) | farm, stree                  | et, factory, office                    |                               | 28f. Loc<br>City                  | ation (Street or Town,            | eet and Numbe<br>State)          | er or Rural            | Route Numb            | ber,       |
|          | To the Hospital or Attanding Physician: The law requires that the death cer within 24 hours state death. The the within 24 hours state death. To the Luneral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use | Medical        | 29a. Certifier 1270<br>(Check only 2 1  | Certifying Phy<br>Medical Exami | rsician: To the best of<br>iner: On the basis of<br>and manner state   | examination a             | lge, death of<br>and/or inve | occurred at the tirestigation, in my c | ne, date and<br>pinion, death | place, and due<br>occurred at the | to the car<br>time, da            | use(s) and ma<br>te and place, a | nner as sta            | ited.<br>the cause(s) |            |
|          | omple  | Me             | 29b. Signature and title o  | f certifier                     | and the state of t |                           |                              | 29c. Licens                            | e number                      |                                   | 29                                | d. Date signed                   | (Month, E              | Day, Year)            |            |
|          | - s + 0  |                | 1 Talal   | - Ta                            | LAL KHA  | ו עו                      | MA                           | 00                                     | 55X                           |                                   |                                   | 7/14                             | 101-                   | , /                   |            |
|          |  | -              | 30. Name and address of   | person who a                    |  |                           | ) (Type P                    | fint)                                  | 700                           | 0                                 |                                   | 111 (1                           | 00                     |                       |            |
|          |  | +              | Talal +   | hair                            | i Mil  | ). 4n                     | 11                           | bry las                                | nd 6                          | Senen                             | al                                | Kersi                            | rita                   | l                     |            |
|          | Sta  | te             | 31. Date filed (Month, Da   | Y Year) 200                     | 32 Registrar   | 's Signature              | 1                            |  |                               |                                   | -                                 | 1 V V J                          | -                      |                       |            |
|          | Registra   | ar             | JUL   | W T TAN                         | De Rus_  | , D.                      | Spa                          | de la                                  |                               |                                   |                                   |                                  |                        |                       |            |

UNKUNK Trice, James D.

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 22944

|   |                        | 1- For State<br>Registrar  |                                 | Cei                       | rtificate of                        | Death         |            |             |             |                 | Red               | No .           | W U           | C In the                                     | / "1    |
|---|------------------------|--|---------------------------------|---------------------------|-------------------------------------|---------------|------------|-------------|-------------|-----------------|-------------------|----------------|---------------|--|---------|
| Physicia  |                        | Decedent's Name (First, Middle)                                  | e,Last)                         |                           |                                     |               |            |             | 2           | 2. Date of      |                   |                |               | 3. Time of Deat                              | :h      |
| edical Exami  |                        | James D. Tr  | ino                             |                           |                                     |               |            |             |             | Month<br>July 3 |                   |                | rear .        | 2001 hrs                                     |         |
| receiving.  |                        | 4a Facility Name (if not institution                             | n, give street and nu           | mber)                     |                                     | b. City, To   | vn, or L   | ocation o   | f Death     | 04.90           |                   |                | ty of Death   | <u>.                                    </u> |         |
|   |                        | 98 West Main Street  |                                 | ,                         |                                     | Westm         |            |             |             |                 |                   | Carrol         |               |  |         |
| Funeral   |                        | 5 Social Security Numberunk                                      | 6. Sex                          | 7 Age (In yrs. I          | ast birthday)                       | If Under      | 1 Year     | If Unde     | r 24Hrs.    | 8. Date         | of Birth          | (MM/DD/YY      |               | thplace (State or                            |         |
| Director  |                        |  | 1 X M 2 F                       | 40                        | O Yrs.                              | Months        | Days       | Hours       | Min.        | Δ110            | 7                 | 1965           | Foreig        | y tand                                       |         |
|   | H                      | Usual Residence of Decedent                                      | 1 23 101 2 1                    |                           | 113.                                |               |            | <u> </u>    |             | nug             | ,,                | 1900           | flat          | yland  |         |
| any   | H                      | 10a. State 10b. County   |                                 | 10c City                  | Town or Locati                      | on            |            |             |             |                 |                   |                |               | 10d Inside City                              | Limits  |
| <b>*</b>  |                        |  | 7.1                             |                           |                                     |               |            |             |             |                 |                   |                |               | 1  |         |
| and sho   | 5                      | MD Carr  | 011                             | We                        | estmins                             | ter           |            |             |             |                 |                   |                |               | 1 Yes 2                                      | X       |
| Maryland<br>28a-f show<br>datonce.  | ect [                  | 10e. Street and Number   |                                 |                           |                                     | 10f. Zip C    | ode        |             |             |                 | 10g               | Citizen of     | What Cou      | ntry?  |         |
| t with the Maryland<br>ms 23a or 28a-f sho<br>be notified at once.  | Director               | 98 West Main   | Street                          |                           |                                     |               | 21         | 157         |             |                 |                   | USA            | A             |  |         |
| with the s 23a  | 폥                      | 11. Mantal Status  | 12. Was Dec                     | edent Ever in U.          | .S 13. Wa                           | s Decedent    | of Hispa   | anic Orig   | in? (Spe    | cify Yes        | or No-            | 14. Ra         | ice - Amer    | ican Indian, Black                           | K.      |
| death wi  | Funeral                | 1 X Never Married 2 M  | arried Armed Fo                 |                           | If Yo                               | es, specify   | Cuban, I   | Mexican,    | Puerto R    | Rican, etc.     | .)                | W              | hite, etc.    |  |         |
| er de   |                        | 3 Widowed 4 Div  | 1 Yes<br>orced If Yes, Give Yea | 2 X No                    | 1                                   | Yes 2 X       | No         | snecify     |             |                 |                   | Specif         | , <b>1</b>    | lack   |         |
| 21215-0036 Jud be filed within 72 hours after Mental Hygiene marked other than "natural"; event, the Medical Examiner   | ğ                      | 15. Decedent's Education (Spe                                    | or Dates:                       |                           | 16a Deceden                         |               |            |             | ind of wo   | ork done        | un Iel            |                |               |  | 1.      |
| hou<br>'nati  | Completed              | Elementary/Secondary (0-12)                                      | College (1                      |                           | during me                           | ost of worki  | ng life. [ | DO NOT      | use retire  | ed)             | ulik              | TOD KING OF    | Dusi lessi.   | industry                                     | unk     |
| 36<br>n 72<br>ran '   | 8                      |  |                                 | - <del>4</del> 01 3+)     |                                     |               |            |             |             |                 |                   |                |               |  |         |
| Neg t   | Ĕ                      | unk  | unk                             |                           |                                     |               |            |             |             |                 |                   |                |               |  |         |
| Hyge d out  |                        | 17 Father's Name (First, Middle,                                 | Last)                           |                           |                                     |               |            |             |             |                 | die, Ma           | aiden Surnar   | ne)           |  |         |
| 21215-0036 and be filed within 7 Mental Hygiene marked other than ic event, the Medica  | Be                     | James Trice  |                                 |                           |                                     |               |            | Audre       |             |                 |                   |                |               |  |         |
| D 21215-0036<br>should be flied within 72 hours after death with the Maryland<br>and Mental Fligeree<br>T is marked other than "natural", or items 23a or 28a-f sho<br>ratic event, the Medical Examiner must be notified at once | 유                      | 19a. Informant's Name/Relations                                  |                                 |                           | 19b. Mailing                        |               |            |             |             |                 |                   |                | own, State    | , Zip Code)                                  |         |
| Baltimore, MD 2121<br>permit Pages I and 2 should be fi<br>Department of Health and Mental<br>Important: If item 27 is marked<br>injury or other traumatic event,   |                        | Michael Trice,   | brother                         |                           |                                     | E1mer         |            |             | Bal         | timo            | re,               | MD 2           | 1215          |  |         |
| Heal I am I tra   |                        | 20a Method of Disposition  |                                 |                           | Place of Dispos<br>crematory or oth |               | of ceme    | etery,      |             | Date            | - [:              | 20c. Locatio   | n - City or   | Town, State                                  |         |
| othe othe   |                        |  | 1 3 Removal fro                 | Jili State                | crematory or ou                     | iei piace)    |            |             |             |                 |                   |                |               |  |         |
| Baltimore,<br>permit Pages I an<br>Department of He<br>Important: If ite  |                        | 4 Donation 5 X Other Sa  | becify: in sta                  | te_l.                     | I aa N                              | ama and A     | drong c    | of Equility |             |                 |                   |                |               |  |         |
| Bal<br>Sermi<br>Depar   | Ш                      | 21. Sign re of Fundial Service                                   | Made,                           | irector                   | Śta                                 | te An         | ator       | ny Bo       | pard        | 655             | W.                | Balti          | more          | Street                                       |         |
|   | _                      | mul surel  | M                               |                           | Da                                  | T L T I I I I | re,        | MD          | 4146        | ) <u>1</u>      |                   |                |               |  | -       |
| Physician   | Ť                      | 23a Part I. Enter the disease, or<br>gilure. List only one cause |                                 | aused the death           | . Do not enter tr                   | ie mode or    | ayırıg, sı | ucri as ca  | ardiac or i | respirator      | y arres           | t, snock, or i | neart         | Approximate In<br>Between Onse               |         |
| /Medical<br>Examiner  |                        | Immediate Cause (Final disease                                   | a. Ketoac                       | idosis co                 | omplicati                           | ng coo        | aine       | use         |             |                 |                   |                |               | Death  |         |
| h.  |                        | or condition resulting in death)                                 | Due to (or as a                 | consequence o             | f):                                 |               |            |             |             |                 |                   |                |               |  |         |
|   |                        | Sequentially list conditions,                                    | b                               |                           |                                     |               |            |             |             |                 |                   |                |               |  |         |
|   | ľ                      | if any, leading to immediate cause. Enter Underlying Cause       | Due to (or as a                 | consequence o             | f):                                 |               |            |             |             |                 |                   |                |               |  |         |
|   | Ē                      | (Disease or injury that initiated                                | C Due to /or on o               | consequence o             | f).                                 |               |            |             |             |                 |                   |                |               |  |         |
| ed  | Examiner               | events resulting in death) Last                                  | ,                               | consequence o             | 1)                                  |               |            |             |             |                 |                   |                |               |  |         |
| recut   |                        | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~                           | d                               | المسلات                   | DIT 27                              | 3.007         | 057        | 7/0//       | OC 1777     |                 |                   |                | _             |  |         |
| 760, icate be executed physician and the burial - transit   | n/Medical              | XUNPENDED  | AMENDED                         |                           | a,PII,27, <sub>1</sub>              | enue, g       | 057,       | // 24/1     | 00 11       |                 |                   |                |               |  |         |
| 8760, tificate be ng physici as the buri  | Ž                      | IF FEMALE:<br>23b Was decedent pregnant in th                    |                                 | outcome of preg           |                                     |               |            |             |             |                 |                   | 23d Date       | ,             |  |         |
| 68<br>Certif  |                        | past 12 months?  | I Live b                        | ırtn<br>ant at time of de | 2 Fet                               |               | 3          | Ectopic     | pregnan     | су              |                   | Month          |               | Day Yea                                      | ar      |
| Box 6:<br>e death cert<br>the attendis  | Sic                    | 1 Yes 2 No 9 Uni   |                                 |                           | eath 5 Oth                          | ner (Specif)  | 1)         |             |             |                 |                   |                |               |  |         |
| . <b>B</b> the d  | Physicia               | Part II. Other significant condit                                |                                 | and the second second     | eculting in the u                   | adarlying     | - auca aiu | on in Par   | + I         | 230 [           | and tob           | 3000 1100 000  | atributa ta   | the cause of deat                            | th?     |
| P.O. Box 68:<br>s that the death certifi<br>gned by the attending<br>e detached for use as  |                        |  | _                               |                           | _                                   | riderlyllig G | ause giv   | remarra     | t I.        |                 | _                 |                |               | pably 4 🗸 Unkr                               |         |
| 9 - 0   | Completed by           | Chronic obstru   | ctive pulmon                    | ary disea                 | ase                                 |               |            |             |             |                 | 165               | 2              | 3 Proc        | ably 4 V Uliki                               | IOWII   |
| cords<br>law requi<br>has been<br>2 should  | et                     |  |                                 |                           |                                     |               |            |             |             |                 | Nas an<br>autopsy |                |               | topsy findings av-                           |         |
| e lav   | Ē                      |  |                                 |                           |                                     |               |            |             |             | F               | erform            | ed?            | death?        |  |         |
| tal Rection: The  |                        | 25 \\\\  |                                 |                           |                                     |               | Diama      | ( D         | 011         |                 | es 2              | No             | 1 <b>V</b> Ye | es 2 1                                       | No      |
| ion of Vital Records,<br>tending Physician: The law required<br>tor: After this certificate has been so<br>the funeral director, page 2 should  | Be                     | 25. Was case referred to medica examiner?                        | Henrital                        |                           |                                     |               |            | of Death (  |             |                 | . — —             |                |               |  |         |
| Physical di   | ို                     | 1 ✓ Yes 2 No   |                                 | npatient 2                | ER/Outpatient                       |               |            |             |             | Home 5          |                   | esidence 6     |               | Scene  |         |
|   | 崩                      | 27. Manner of Death  1 X Natural 5 Page                          | 28a. Date<br>(Month             | of Injury<br>, Day,Year)  | 28b. Time of Ir                     | · ·           |            | at Work?    |             | 8d Desc         | ribe ho           | w injury occu  | urred         |  |         |
| ior<br>tend<br>teath<br>tor:  | ij                     | Pend   | ding<br>stigation               |                           |                                     |               | Ye         | s 2         | No          |                 |                   |                |               |  |         |
| Division<br>tal or Attendi<br>rs after death<br>al Director: /  | i <u>i</u>             |  |                                 | e of Injury - At h        | ome, farm, stree                    | t, factory, o | ffice bui  | ilding, etc | . 2         |                 |                   |                | nber or Ru    | ral Route Number                             | r, City |
| Divisipital or At ours after deral Direct filled in by  | er                     |  | rmined (Specify)                |                           |                                     |               |            |             |             | or 10/          | wn, Star          | te)            |               |  |         |
|   | Medical Certification: | 29a Certifier  | nysician: To the bes            | t of my knowled           | ge, death occur                     | ed at the ti  | ne, date   | e and plac  | ce, and d   | ue to the       | cause(            | s) and manr    | er as start   | ed   |         |
| To the Hos<br>within 24 h<br>To the Fur<br>completely   | 5                      |  | miner:On the basis of           | of examination a          |                                     |               |            |             |             |                 |                   |                |               |  |         |
| To Mit  | Me                     | 29b. Signature and title of certifie                             | and manner s                    | tated                     | ·                                   | 29c l         | icense     | number      |             |                 | 12                | 29d Date sid   | aned (Mor     | nth, Day, Year)                              |         |
|   |                        |  | 01                              | 11                        |                                     |               | D.C.M      | E           |             |                 |                   |                |               | , Day, 100.,                                 |         |
|   |                        |  | NVI-                            | 11                        |                                     |               | J IVI      |             |             |                 |                   | July 4, 20     |               |  |         |
|   |                        | 30 Name and address of per                                       |                                 |                           |                                     |               |            |             |             |                 |                   |                |               |  |         |
|   |                        | Jack Titus MD. Dep   | outy Chief Medic                | al Examine                | r 111 Pen                           | n Street,     | Baltir     | more, N     | /ID 212     | 201             |                   |                |               |  |         |
|   | ate                    | 31. Date filed (Month, Day, Year)                                | 2000                            | gistrar's Signatu         |                                     | 40            |            |             |             |                 |                   |                |               |  |         |
| Regist  | rar                    | JUL 2 1 7  | UUb Kila                        | ence It                   | Span                                | W.            |            |             |             |                 |                   | -              |               |  |         |
| DHIVIH 17 Rev 1/Z   | DUT                    |  |                                 |                           | ORIGINAL                            |               |            |             |             |                 |                   |                |               |  |         |

|            |  |                | For State Registrar   | State                                   | of Mary  | land / Depa<br><i>Cei</i>                 | rtment o                       |                              |                                   | lental Hy                          | gien<br>Reg. N | / 11                       | 06                     | 22                       | 945           |
|------------|--|----------------|---|---|--|---|--------------------------------|------------------------------|-----------------------------------|------------------------------------|----------------|----------------------------|------------------------|--------------------------|---------------|
|            |  |                | Decedent's Name (First, Middle  | Last)                                   |  |   |                                |                              |                                   | 2. Date of De<br>Month             |                | ay                         | Year                   | 3. Time o                | of Death      |
|            | Physici<br>/Medic  |                | Dorothy Wise T  | aylor                                   |  |   |                                |                              |                                   | June 2                             |                |                            | 1021                   | 4:30                     | AM M          |
|            | Examin   |                | 4a. Fecility Name (If not institution,  |   |  |   |                                | - '                          | ation of Death                    |                                    | 4              | c. County o                |                        |                          |               |
|            |  |                | 100 Revolution 5, Social Security Number  | Street<br>6. Sex                        | _  | yrs. last birthday)                       |                                | e de (                       | Grace                             | 8. Date of Bi                      | rth            | Harf                       |                        | lace (State              | or Foreign    |
|            | Funeral Director   |                | 219-05-0589   | 1 M 2 M F                               |  | 86 Yrs.                                   |                                |                              | ours Min.                         | Feb 29                             | ay, Year       | )                          | Countary]              | try)                     | or Foreign    |
|            |  |                | Usuel Residence of Decedent   |   | _1   | 00  |                                |                              |                                   | TCD ZJ                             | ,              | 20 1.                      | iaryi                  | .and                     |               |
|            | yland  |                | 10a. State 10b. County  |   | 10   | c. City, Town or Lo                       | cation                         |                              |                                   |                                    |                |                            | 1                      | 0d. Inside (             |               |
|            | Ba-f.  | cto            | MD Har:   | ford                                    |  | Havre d                                   | e Grace                        | e                            |                                   |                                    |                |                            |                        |                          | s 2 No        |
|            | 라 다<br>or 28   | Director       | 10e. Street and Number  |   |  |   | 10f. Zip Co                    |                              |                                   |                                    | 10g. C         | ifizen of WI               |                        | try?                     |               |
|            | be filed within 72 hours after death with the Maryland tal Hygiene.  dother than "natural", or Items 23a or 28a-f ehow event, the Midical Examinar must be notified at |                | 100 Revolution  |   |  |   | Mar Daniel                     |                              | 078                               | 4. V N                             |                | US<br>14. Rece             |                        | on Indian                |               |
|            | ltem.  | Funeral        | 11. Marital Status  1 ☐ Never Married 2 ☒ Marri   | Armed                                   | ecedent Ever<br>Forces?<br>s 21 No             | 'in U.S. 13. 1                            | Yas Decedent<br>f Yes, specify | Cuban, Me                    | exican, Puerto                    | ecify Yes or N<br>Rican, etc.)     | 0-             |                            | , White,               |                          |               |
| 5          | Irs aff  | by             | 3 Widowed 4 Divorced  | If Yes, (                               | Give   |   | I□Yes 2∑                       | No Spe                       | ecity:                            |                                    |                | Specify:                   | whi                    | te                       |               |
| 21215-0036 | within 72 hours after<br>ene.<br>then "neturel", or Ite<br>ne Modest Examine   |                | 15. Decedent  |   | -d)  | 16a. Deced                                | tent's Usual C                 | Occupation                   | most of worki                     | 100                                | 16b.           | Kind of Bus                | iness/Inc              | lustry                   |               |
| 7          | thin 7   | ple            | (Specify only highes<br>Elementary/Secondary (0-12)   |   | (1-4or 5+)                                     | life.                                     |                                |                              | THOSE OF WORK                     | ing .                              |                |                            |                        |                          |               |
|            | filed wi<br>Hygien<br>other th   | Completed      | 12  | 0                                       |  |   | prin                           |                              |                                   | 450 a 441 444                      | _              | elf e                      |                        | yed                      |               |
| and        | ild be fill<br>lental H<br>ked oth<br>ic even  | Be             | 17. Father's Name (First, Middle, I   |   |  |   |                                |                              |                                   | e (First, Middle<br>telle I        |                |                            | )                      |                          |               |
| 2          | 2 should be and Mental is marked (sumatic ev   | ဥ              | Alfred Augustu  19a. Informant's Name/Relationsh  |   |  | 10h Mailie                                | - Addrson (C                   |                              |                                   | al Route Numb                      |                |                            | tata Zin               | Codol                    |               |
| Mary       | カニトラ   |                | Warner Taylor/s   |   |  |   |                                |                              |                                   | #111 На                            |                |                            |                        |                          | 21078         |
| a)         | permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marke any injury or other traumatic QUCS.   |                | 20a. Method of Disposition  | _                                       | 2  | Ob. Place of Dispo                        | sition (Name                   | of                           |                                   | Date                               |                | ocation - C                |                        |                          |               |
| ᅙ          | ages<br>ant of<br>t: If if   |                | 1 ☐ Burial 2 ☐ Cremation  4 ☑ Donation 5 ☐ Other (Sp  |   | m State  | cemetery, crer                            | natory or othe                 | er piace)                    |                                   |                                    |                |                            |                        |                          |               |
| Baitimore, | nit. Fartment outsi  |                | 21. Signature of Funeral Service L  | icensee                                 | v. 11  | C <sup>22</sup>                           | Name and A                     | Address of F                 | Facility                          | 655 W.                             | D - 1          | 1                          |                        |                          |               |
| ñ          | Deg and a  | 0.0            | Ronald S  | . wade,                                 |  |   | ate An<br>ltimor               |                              |                                   |                                    | ва.            | Ltimo                      | re S                   | treet                    | 4             |
|            | *  |                | 23a. Part1. Enter the disease, or shock, or heart failure. List   | complications tha                       | t caused the                                   | death. Do not ent                         | er the mode o                  | of dying, suc                | ch as cardiac o                   | or respiratory a                   | rrest,         |                            |                        | Approxima<br>Interval Be | neewle        |
|            | Physician  |                | Immediate Cause (Final disease or condition   |   |  | ARTERY D                                  | ISEASE                         |                              |                                   |                                    |                |                            |                        | Onset and                | Death<br>ears |
|            | /Medical<br>Examiner   |                | resulting in death)   |   |  | nsequence of):<br>ZED ARTER               | IOSCLE                         | ROSIS                        | 8                                 |                                    |                |                            |                        | 15 y                     | ears          |
|            | pe și  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. ———————————————————————————————————— | to (or as a co                                 | insequence of):                           |                                |                              |                                   |                                    |                |                            |                        |                          |               |
|            | the death cer ilicate be executed y the attending physician and iched for use is the burial-transit  | хап            | that initiated events<br>resulting in death) Last   | c                                       | to (or as a co                                 | insequence of):                           |                                |                              |                                   |                                    |                |                            | -                      |                          |               |
| 9/60       | ficate be ex<br>physician<br>s the burial  | dicalE         |   |   |  |   |                                |                              |                                   |                                    |                |                            |                        |                          |               |
| 200        | ificate<br>3 phy<br>s the  | 0              |   | 0.                                      | 3237   |   |                                |                              |                                   |                                    |                |                            |                        |                          |               |
| ROX        | eath certific<br>attending p   | Physiclan/M    | IF FEMALE:<br>23b. Was decedent pregnant  |   | outcome of p                                   |   | Ectopic pregi                  | nancy                        |                                   |                                    |                | 23d. Date                  |                        | -                        |               |
|            | deat   | sicla          | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  |   | gnant at time                                  |   | Other (speci                   |                              |                                   |                                    |                | Mont                       | th                     | Day                      | Year          |
| J.         | at the de<br>s by the<br>stached   | Phy            | 9 Unknown   |   |  |   |                                |                              |                                   | con Did                            |                |                            |                        |                          | danah?        |
| Hecords,   | The law requires that<br>ite has been signed b<br>age 2 should be deta   | þ              | Part II. Other significant condition CHRONIC OBSTR  | •                                       |  | -   | , -                            | se given in i                | Paπ I.                            |                                    |                | use confrit                |                        |                          |               |
| ပ္က        | aw re  | Completed      | RESPIRATORY I   | NSUFFICI                                | ENCY   |   |                                |                              |                                   | 24a. Was                           |                | 24b. W                     | ere autor              | osy findings             | available     |
| ř          | sicien: The law<br>certificate has l<br>irector, page 2 s  | E O            |   |   |  |   |                                |                              |                                   | perf                               | ormed?         | de                         | ath?                   |                          | J4436 01      |
| Vital      | ien:<br>artifica<br>ctor.  | Bec            | 25. Was case referred to medical examiner?  | -1                                      |  |   |                                |                              | Place of Death                    | h (Check only                      |                |                            |                        |                          |               |
| 5          | Physicien:<br>r this certific<br>ral director,   | 2              | 1 ☐ Yes 2 ☐XNo  |   | Inpatient                                      | 2 ER/Outpatien                            |                                | -                            |                                   | me 5 🗓 Res                         |                |                            |                        | ')                       |               |
| Ĕ          | ding P.<br>h.<br>After t   | on;            | 27. Manner of Death 1   Matural 5   Pending   | 9                                       | te of Injury<br>onth, Day Ye                   | ar) 28b. Time of Injury                   |                                | Work?                        |                                   | 28d. Describe                      | how inj        | nry occurre                | d                      |                          |               |
| <u> </u>   | or:  | Icat           | 2 Accident investig   | ot be 200 Pla                           | ice of Injury                                  | At home, farm, str                        | M eat factory o                | 1 Tes                        |                                   | 28f. Location                      | Street a       | nd Numbei                  | r or Rum               | i Route Nu               | mber          |
| Division   | after de<br>Direct<br>d in by t  | Certification; | 4 ☐ Homicide determ   | ned bu                                  | ilding, etc. (S                                | Specify)                                  | ooi, lactory, o                | 31100                        |                                   | City or To                         |                |                            |                        |                          |               |
|            | Hospite<br>t hours<br>unerel<br>ely fille  | edical C       | 29a. Certifier 1 Certifyin (Check only 2 Medical (  | Examiner: On the                        | the best of me<br>basis of exa<br>anner stated | y knowledge, death<br>amination and/or in | occurred at vestigation, in    | the time, da<br>n my opinion | ate and place,<br>a, death occurr | and due to the<br>red at the time. | cause(         | s) and man<br>nd place, ar | ner as st<br>nd due to | ated.<br>the cause(      | s)            |
|            | To the Hos<br>within 24 h<br>To the Fur<br>completely  | Me             | 29b. Signature and title of certifier   |   |  | /   | 29c. L                         | icense num                   | nber                              |                                    | 29d. D         | ate signed                 | (Month, I              | Day, Year)               |               |
|            | . , , , ,  |                | · /M  | e ale                                   | SM   | uch                                       | D                              | 15994                        |                                   |                                    | (              | 06-27-                     | -06                    |                          |               |
|            |  |                | 30. Name and address of person  |   |  |   |                                |                              |                                   |                                    |                |                            |                        |                          |               |
|            |  |                | Leticia S. Ga   |   |  |   | on Ave                         | nue,                         | Havre d                           | ie Grac                            | e, N           | 1D 21                      | 1078                   |                          |               |
| 差          | Sta<br>Regista   |                | 31. Date filed (Month, Day, Year)  JUL 2 1 2  | 006                                     | . Registrar's                                  | Signature Spa                             | W                              |                              |                                   |                                    |                |                            |                        |                          |               |

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Month **Physician** Year Francis Gerard Trageser July 16, 10:45A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8450 Bay Drive Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. 10/05/1922 5. Social Security Number 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) <u>Funeral</u> 1**⊠** M 2□ F Director 216-12-3370 83 MD Usual Residence of Decedent the Maryland Show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Exerciner must be notified at 1 ☐ Yes 2 KNo Director 28a-f MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Itams 23a 21122 U.S.A. 8450 Bay Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1942 — If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and 2 should be filed within 3 ealth and Mental Hygiene. m 27 Is markad othar than "r Elementary/Secondary (0-12) College (1-4or 5+) 4 Electrical Engineer Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John F. Trageser Catherine M. Wellein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or other trai Mary Frances Trageser/Wife 8450 Bay Drive, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 07/21/06 Crownsville, MD MD\_Veterans Cem 21. Signature of Funeral Service Ligansee 22. Name and Address of FacilityG.J.Gonce Funeral Home, PA 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Immediate Cause (Final INFARCTION Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner transit The law requires that the death certificate be executed that initiated events resulting in death) Last and physician an s the burial-tr Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 010 24a. Was an performed? 1 ☐ Yes 1 Yes 2 No 2 **2** No o tha Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 2 3□ DQA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date, signed (Month, Day, Year) 0002519 MD 1010ena completed cause of death (Item 23a) (Type, Print) CRAIN TOWERS, GLEN BURNIE, 21061 FISHER 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

|                               |   |                     | 1 - For<br>State<br>Registrar   |  | f Marylar                              |   | artment<br>rtificate                       |                         |                         |                         | _                               | gien<br>Reg. N         | 200                              | 6                  | 22  | 947                  |
|-------------------------------|---|---------------------|---|--|--|---|--|-------------------------|-------------------------|-------------------------|---------------------------------|------------------------|----------------------------------|--------------------|---|----------------------|
| ı                             | Physici   |                     | Decedent's Name (First, Middle     DOROTHY M  | ARGARET  | VOLK                                   |   |  |                         |                         |                         | 2. Date of De<br>July 2         |                        |                                  | ear                | 3. Time o                                 |                      |
|                               | /Medio<br>Examir  |                     | 4a. Facility Name (If not institution 6015 Carter   |  | nber)                                  |   | 4b. City, 1                                | Fown, or Bal            | Location o              | of Death                |                                 |                        | c. County of                     | Death              |   |                      |
|                               | Funeral<br>Director   |                     | 5. Social Security Number 213-60-1853   | 6. Sex<br>1 ☐ M 2 🔀 F                                | 7. Age ( <i>in yrs</i> . <b>79</b>     | last birthday)<br>Yrs.                          | If Under<br>Months                         | 1 Year<br>Days          | If Under:<br>Hours      | 24 Hrs. Min.            | 8. Date of Bir<br>Apr 6,        | 1927                   | ) 9                              | Birthp<br>Mar      | yland<br>Yland                            | or Foreign           |
|                               | yland   |                     | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. Cit                               | y, Town or Lo                                   |  |                         |                         |                         |                                 |                        |                                  | 1                  | 10d. Inside C                             | City Limits          |
|                               | 89-1 el   | ector               | MD  |  |  | Ва<br>———                                       | ltimo                                      |                         |                         |                         |                                 |                        |                                  |                    |   | 2 No                 |
|                               | h with t  | I D                 | 6015 Carter Av  | enue   |  |   | 10f. Zip (                                 |                         | 214                     |                         |                                 | 10g. C                 | itizen of What                   |                    | itry?                                     |                      |
| 920                           | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "naturel", or Iteme 23a or 28a-f show aumatic event, the Mudical Exactil activation to inclined at | by Funeral Director | 11. Marital Status  1 Never Married 2 Marr  3 Widowed 4 Divorced  | Armed Fo   | 2 <b>∏</b> No<br>'e                    |   | Was Decede<br>f Yes, speci<br>1 Yes 2      |                         | spanic Origin, Mexican  | gin? (Spe               | ecify Yes or No<br>Rican, etc.) | )-                     | 14. Race -<br>Black,<br>Specify: | White,             |   |                      |
| 5-0                           | natur<br>"natur   | eted                | 15. Deceden<br>(Specify only highes   | 's Education st grade completed)                     |  | 16a. Dece                                       | dent's Usual<br>kind of work<br>DO NOT use | Occupat<br>done du      | tion<br>uring most      | t of worki              | ng                              | 16b. F                 | Cind of Busin                    | ness/In            | dustry                                    |                      |
| 212                           | d withir<br>glene.<br>r then  | Completed           | Elementary/Secondary (0-12) 1 2   | College (1   | -4or 5+)                               | H   | omema                                      | ker                     |                         |                         |                                 | 1                      | At H                             | ome                | ž   |                      |
| altimore, Maryland 21215-0036 | uld be file<br>Mental Hyg<br>irked other<br>itic event,   | To Be C             | 17. Father's Name (First, Middle,<br>Herman Zim   | ,  |  |   |  |                         |                         |                         | (First, Middle,<br>Jurge        |                        |                                  |                    |   |                      |
| , Man                         | and 2 sho<br>alth and 1<br>27 is mu   |                     | 19a. Informant's Name/Relations Beverly J.  | nip <i>(Type, Print)</i><br>Volk–dau                 | ighter                                 | 19b. Mailin                                     | og Address<br>5 Car                        | street ar               | nd Numbe<br>Ave         | or or Rum<br>enue       | -Balti                          | er, City<br>LMO1       | or Town, Sta                     | te, <i>Zip</i>     | Code)<br>1214                             |                      |
| more                          | permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other traumatic evance.  |                     | 20a. Method of Disposition  X☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S                               |  | State HO                               | lace of Dispo<br>emetery cren<br>TTIT<br>thodox | iity k                                     | üssi                    | an 7                    | 7–24-                   | -06                             | 20c. L<br>E <b>lkr</b> | ocation - Cit                    | y or To<br>Mar     | wn, State<br>yland                        |                      |
| Balt                          | permit. Departr Importe any inju  |                     | 21. Signature of Funeral Service  | Licensee<br>MS Lao                                   | lden                                   | 88  | Name and                                   | Address                 | ord                     | EVA<br>Roa              | NS CHZ<br>d-Park                | APEI                   | OF<br>Tle,M                      | MEN<br>D 2         | 10RIE                                     | S                    |
| i                             |   |                     | 23a. Part1. Enter the disease, or shock, or heart failure. List   | complications that conty one cause on e              | aused the deat<br>ach line.            | h. Do not ent                                   |  |                         |                         | cardiac o               | r respiratory a                 | rrest,                 |                                  |                    | Approximat<br>Interval Bet<br>Onset and I | meem                 |
|                               | Physician /Medical  |                     | Immediate Cause (Final disease or condition resulting in death)   | a. Due to (  | or as a conseq                         | uence of):                                      | cin  | ON                      | na_                     |                         | -                               |                        |                                  | -                  | 7 mor                                     |                      |
|                               | Examiner  |                     | Sequentially list conditions.   | b  | <u> </u>                               |   |  |                         |                         |                         |                                 |                        |                                  |                    |   |                      |
|                               | Insit   | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (   | or as a conseq                         | uanda ol).                                      |  |                         |                         |                         |                                 |                        |                                  |                    |   |                      |
| Ŏ,                            | icate be executed physicien and stransit sthe burial-transit  | Exa                 | that initiated events resulting in death) Last  | c.<br>Due to (                                       | or as a conseq                         | uence of):                                      |  |                         |                         |                         |                                 |                        |                                  |                    |   |                      |
| 68760                         | ficate by physic ts the b   | edical              |   | d  |  |   |  |                         |                         |                         |                                 |                        |                                  |                    |   |                      |
| O. Box                        | that the death certificate be executed to by the attending physicien and and detached for use as the burial-transit   | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ⚠ No 9 ☐ Unknown                     |  | irth 2 Tetel<br>ant at time of de      | death 3   | Ectopic pre<br>Other (spe                  |                         |                         |                         | <del></del>                     |                        | 23d. Date o<br>Month             |                    | ,   | Year                 |
| 1                             | sign sign   | Ď                   | Part II. Other significant condition  | ns contributing to de                                | ath but not resi                       | ulting in the ur                                | iderlying ca                               | use giver               | n in Part I.            |                         |                                 | obacco<br>res 2        | _                                | te to th           | ne cause of d                             | leath?<br>Inknown    |
| Vital Records,                |   | Completed           |   |  |  |   |  |                         |                         |                         |                                 |                        | prior                            | r to con<br>h?     | psy findings and pletion of ca            | available<br>ause of |
| V Ita                         | certific<br>rector,   | Be                  | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ₺ No   | Hospital:  |  |   |  | Other                   |                         |                         | Check only o                    | nel                    |                                  |                    |   |                      |
| o<br>To                       | og Phys<br>ter this<br>neral di   | n: To               | 27. Manner of Death   | 28a. Date o  |  | ER/Outpatien<br>28b. Time of<br>fnjury          |  | c. Injury a             | 4 🗆 Nur                 |                         | ne 5 Resid<br>8d. Describe h    |                        |                                  | Specify            | )   |                      |
| DIVISION                      | Attending<br>r death.<br>ector: After<br>by the fune  | catic               | t Agtural 5 Pending 2 Accident investig 3 Suicide 6 Could r   | ation  |  |   | М  | 1 🗆 Y                   | es 2□N                  |                         |                                 |                        |                                  |                    |   |                      |
| 2                             | s after   | Certification:      | 4 ☐ Homicide determi  | ned 286. Flace<br>buildir                            | of Injury - At ho<br>ig, etc. (Specify | nne, rarm, stre                                 | eet, factory,                              | опісе                   |                         | 2                       | 8f. Location (S<br>City or Tox  | vn, State              | e)                               | r Hurai            | Houte Num                                 | ber,                 |
|                               | To the Hospital or Attentwithin 24 hours after deation to the Funeral Director: completely filled in by the   | edical              | 29a Certifier 1 Certifyin (Check only one)  | Physician: To the<br>Examiner: On the ba<br>and mann | isis of examinal                       | wladge death<br>tion and/or inv                 | estigation, i                              | t the time<br>n my opir | data and<br>nion, deatl | l place, a<br>h occurre | nd due to the e                 | date and               | and manne<br>d place, and        | r as sta<br>due to | the cause(s                               | )                    |
|                               | To t<br>To t  | Σ                   | 29b. Signature and title of certifier   | Do all was   |  |   | 1  | License                 |                         |                         |                                 |                        | te signed (M                     |                    |   |                      |
|                               | 4   | 1                   | 30. Name and address of person  | who completed cause                                  | of death (Item                         | 23a) (Type, I                                   | Print)                                     | کاری (                  | 81.L                    | ) R                     | altimo                          | 100                    | Na.                              | , Z<br>-<br>717    | 39  |                      |
|                               | Sta   | te                  | 31. Date filed (Month, Day, Year)   | 1  | egistrar's Signa                       | ture  |  | CIL                     | with                    | -> 10                   | millin                          | 100                    | 2000                             | dan Co             | 71  |                      |
|                               | Registr   | ar                  | JUL 21  | 2006   | was b                                  | : Ope   | de   |                         |                         |                         |                                 |                        |                                  |                    |   |                      |

|                                 |  |                             | Please   | State of Maryland  |                              |  |   | •                                    | _                                    |   |
|---------------------------------|--|-----------------------------|--|--|------------------------------|--|---|--------------------------------------|--------------------------------------|---|
|                                 |  | •                           | For<br>State<br>Registrer  | State of Maryland  |                              | tificate of                            |   |                                      | 2006                                 | 22943   |
|                                 |  |                             | Decedent's Name (First, Middle, Last   | ·)   |                              | tiriodio or                            |   | 2. Date of Death                     |                                      | 3. Time of Death                                |
|                                 | Physicia   |                             | JOHN   | WIDMYER  |                              |  |   | Month<br>07                          | Day Year                             | 12:30 PM  |
|                                 | /Medic<br>Examin   |                             | 4a. Facility Name (If not institution, give  |  |                              | 4b. City, Town, o                      | r Location of Death                         |                                      | 4c. County of Dea                    |   |
|                                 |  | -                           | Manor Care of Woo  | odbridge   |                              | Ca                                     | tonsville                                   |                                      | Ba1                                  | timore  |
|                                 | Funeral  |                             | 5. Social Security Number 6. Se  |  |                              | If Under 1 Year<br>Months Days         | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birth<br>(Month, Day, Y   | (ear) 9. Birt                        | hplace (State or Foreign puntry)                |
|                                 | Director   |                             | 219-30-8956 Usual Residence of Decedent  | ∑M 2□F 71  | Yrs.                         |  |   | Jan. 9,                              | 1935 Ma                              | ryland  |
|                                 | and and  | 1                           | 10a. State 10b. County   | 10c. City  | , Town or Lo                 | cation                                 |   |                                      |                                      | 10d. Inside City Limits                         |
|                                 | Mary<br>-f sh  | tō                          | MD Baltin  | nore   |                              | Haleth                                 | orpe  |                                      |                                      | 1 ☐ Yes 2 🚻 No                                  |
|                                 | r 28e  | Director                    | 10e. Street and Number   |  |                              | 10f. Zip Code                          |   | 100                                  | g. Citizen of What Co                |   |
|                                 | 2 should be filed within 72 hours efter deeth with the Maryland end Mental Hyglene. Is marked other than "natural", or Itema 23a or 28e-f show termatic event, it is Medical Examinar must be invitred at  |                             | 1015 Francis Aver  | nue  |                              | 21:                                    | 227   |                                      | United S                             | tates   |
|                                 | ema<br>erra  | Funerai                     | 11. Marital Status   | 12. Was Decedent Ever in U.S<br>Armed Forces?  | 3. 13.                       | Was Decedent of H                      | lispanic Origin? (Sp<br>an, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)     | 14. Race - Ame<br>Black, Whit        |   |
| 36                              | s efte   | by Fu                       | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced                             | 1 X Yes 2 ☐ No<br>If Yes, Give   |                              | 1□Yes 2\ No                            | Specify:                                    |                                      | Specify:                             | White   |
| Ö                               | hour<br>tural  | ed b                        | 15. Decedent's Edi   | Year or Dates:   | 16a Deced                    | tent's Usual Occur                     | pation                                      | 16                                   | Bb. Kind of Business                 | (Industry                                       |
| 5                               | in 72<br>n "na<br>Agulio   | piet                        | (Specify only highest grad   | de completed)  College (1-4or 5+)  | (Give<br>life. L             | kind of work done<br>OO NOT use retire | oation<br>during most of work<br>d)         | ing                                  |                                      | re County                                       |
| 212                             | d with   | Completed                   | 12   | College (1-401 5+)   | G                            | roundsme                               | n   |                                      | Schools                              |   |
| 9                               | A  | Вес                         | 17. Father's Name (First, Middle, Last)  |  |                              |  | 18. Mother's Nam                            | e (First, Middle, Ma                 | aiden Sumame)                        |   |
| yla                             | Ment<br>arked<br>arked   | 2                           | Richard Joseph Wi  |  |                              |  |   |                                      | eth Walsh                            |   |
| Maryland 21215-0036             | 2 sho  |                             | 19a. Informant's Name/Relationship (T)   |  |                              | •                                      |   |                                      | City or Town, State, 2               |   |
|                                 | l and<br>lealth<br>im 27<br>ihar t   |                             | Linda Klein, Daug  |  |                              | Francis A                              |   | -                                    | e, MD 2122<br>Oc. Location - City or |   |
| Baltimore,                      | permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic ex once.  |                             | 1   Burial 2 □ Cremation 3 □1  | Removal from State   | udon P                       | natory or other plac<br>ark            | ce)   |                                      |                                      |   |
| 를                               | it. Partme   |                             | 21 Signature of Funeral Service Licens   |  |                              | etery                                  |   |                                      | Baltimore,<br>eral Home,             |   |
| Ba                              | permi<br>Depa<br>Impo<br>any ir  |                             | The Maria  | 6 UDOL   | /                            |  |   |                                      | erai Home,<br>sdowne, MD             |   |
|                                 |  |                             | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of    | lications that caused the eath   | . Do not ent                 | er the mode of dyir                    | ng, such as cardiac                         | or respiratory arres                 | t,                                   | Approximate                                     |
|                                 | Physician  |                             | Immediate Cause (Final   | and the same of th |                              |  |   |                                      |                                      | Interval Between<br>Onset and Death             |
|                                 | /Medical   |                             | disease or condition resulting in death)   | a. CORUNARY Due to (or as a consequ  |                              | 7 21-7                                 | 1)1526                                      | 7                                    |                                      |   |
|                                 | Examiner   |                             | Conventially list conditions   | b  |                              |  |   |                                      |                                      |   |
|                                 | ש יו   | iner                        | Sequentially list conditions, it any, leading to immediate cause. Enter Underlying | Due to (or as a consequ  | ence of):                    |  |   |                                      |                                      |   |
|                                 | and<br>and   | Examiner                    | Cause (Disease or injury that initiated events resulting in death) Last            | c<br>Due to (or as a consequ   | ieuce ot).                   |  |   |                                      |                                      |   |
| 60,                             | te be executed<br>ysician and<br>e burial-transit  | calE                        |  |  |                              |  |   |                                      |                                      |   |
| ~                               | w ~ w  |                             |  | d  |                              |  |   |                                      |                                      |   |
| Box (                           | leath certificate<br>attending phy<br>I for use as the   | M/M                         | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome of pregnar  |                              | Te                                     |   |                                      | 23d. Date of de                      | ivery   |
| Ď.                              | death<br>e atte  | Completed by Physician/Medi | in the past 12 months?   | 1 Live birth 2 Fetal 4 Pregnant at time of de  |                              | Ectopic pregnancy Other (specify) _    | y<br>                                       |                                      | Month                                | Day Year  |
| o.                              | that the de  | hys                         | 9 Unknown  | 9□ Unknown   |                              |  |   |                                      |                                      |   |
| S,                              | res tha<br>igned<br>be de  | by                          | Part II. Other significant conditions co   |  | ilting in the u              |  | en in Part I.                               | 23e. Did toba                        | cco use contribute to                | o the cause of death?  obably 4 DUnknown        |
| ord                             | w require<br>been sign   | eted                        | 17rz IL DIA  | BETES ME   | / ا                          | <u> </u>                               |   |                                      | 20140 3011                           | ODADIY 4 DONKIOWII                              |
| Sec.                            | e law<br>has b   | mpie                        |  |  |                              |  |   | 24a. Was an autopsy performe         | prior to                             | topsy findings available completion of cause of |
| a                               | r. Th  |                             |  |  |                              |  |   | 1 ☐ Yes 2                            | PNo 1 □ Yes                          | 2 No  |
| Ĭ                               | siciar<br>certif<br>recto  | Be C                        | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No                          | Hospital: 1 ☐ Inpatient 2 ☐ I  | EB/Outroti-                  | ott                                    |   | h (Check only one)                   | ce 6 □Other (Spe                     |   |
| oţ                              | r this   | .: To                       | 27. Manner of Death  | 28a. Date of Injury<br>(Month, Day Year)   | ER/Outpatier<br>28b. Time of |  |   | 28d. Describe how                    |                                      | city)   |
| lon                             | th.<br>:: Afte   | tior                        | 1 ☑Natural 5 ☐ Pending<br>2 ☐ Accident investigation                               |  | Injury                       |  | rk?<br> Yes 2 ☐ No                          |                                      |                                      |   |
| Division of Vital Records, P.O. | Atternation of the part of the | ifice                       | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At ho<br>building, etc. (Specify  | me, farm, str                | eet, factory, office                   |   | 28f. Location (Stre<br>City or Town, | et and Number or R                   | ural Route Number,                              |
| Ö                               | rs after all Direction   | Certification;              |  | Salaring, Sto. Topasily  | ,                            |  |   | ., ,,                                |                                      |   |
|                                 | To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely fitted in by the funeral director, page 2 should be detached for use as the   |                             | (Check only 2 Medical Exam   | ysician: To the best of my know<br>iner: On the basis of examinat  |                              |  |   |                                      |                                      |   |
|                                 | the I  | Medicai                     | one) 29b. Signature and title of certifier   | and manner stated.   |                              | 29c, Licens                            |   |                                      | d. Date signed (Mont                 |   |
|                                 | P F P  |                             | 250. Signature and title of certifier  | M·D  |                              |  | 59107                                       |                                      |                                      |   |
| Y                               | X  |                             | 30. Name and address of person who of  |  | 23a) (Type                   | 1                                      | ZINT  |                                      | 07-17-2                              | - 400   |
| 3                               | . 1  |                             | KAL: UMA   | 219 BUSINESS   |                              |  | IVE REN                                     | TERSTON                              | in mo                                | 2-1136  |
|                                 | Sta  | te                          | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signal   | Turk SAN                     | 9                                      |   | y . C                                | <u> </u>                             |   |
|                                 | Peniet   |                             | THE Z T TOO  | 1152 FELFE   | -                            |  |   |                                      |                                      |   |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2.0.0.0

| 15. Decedednt's Education (Specify only highest grade completed)  (Specify only highest grade completed)  (Specify only highest grade completed)  (Specify only highest grade completed)  (Give kind of work done during most of working life. Do NOT use retired)  Property Manager  16b. Rind of Business/Industry  (Give kind of work done during most of working life. Do NOT use retired)  Property Manager  17. Father's Name (First, Middle, Last)  Francis Windsor  18. Mother's Name (First, Middle, Maiden Surname)  Ethel Brown  19a. Informant's Name/Relationship (Type, Print) (Wife)  Mrs. Carol Hungerford Windsor  20b. Place of Disposition (Name of Date 20c. Location of City or Town, State, Zip Code)  20c. Location of City or Town, State, Zip Code)   | M eign       |
|--|--------------|
| ## As Facility Name (If not institution, give street and number)    Montgomery County General Hospital   4b. City, Town, or Location of Death   Montgomery   Montgomery   Montgomery   Montgomery   Montgomery   Montgomery   Montgomery   Montgomery   Montgomery   Montgomery   Montgomery   Montgomery   Montgomery   Montgomery   Months   Days   Hours   Min.   Months   Days   Hours   Min.   Months   Days   Months   Days   Hours   Min.   Months   Days   Months   Days   Hours   Min.   Months   Days   Pass  | əign<br>nits |
| Montgomery County General Hospital  Olney  Montgomery  Montgomery  Montgomery  Montgomery  Montgomery  101-19-19-19-19-19-19-19-19-19-19-19-19-19  | nits         |
| Director    Superior   Control   Con | nits         |
| 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim MD Carroll Sykesville 10b. Street and Number 460 Oklahoma Avenue 21784 USA  11. Marital Status 1. Lyes 2 2 No. Specify: USA  11. Marital Status 1. Lyes 2 No. Specify: USA  11. Marital Status 1. Lyes 2 No. Specify: USA  15. Decedent's Education (Specify only highest grade completed) (Francis Windsor)  16a. Decedent's Usual Occupation (Give kind of working life. Do Not use relired)  17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (Type, Print) (Wife)  19a. Informant's Name/Relationship (Type, Print) (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Method of Disposition (Name of Disposition (Name of Disposition (Name of Disposition) (Na |              |
| 1   Never Married   2   Married   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   Yes      | No           |
| 1   Never Married   2   Married   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   Yes      |              |
| 1   Never Married   2   Married   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   Yes      |              |
| 19a. Informant's Name/Relationship (Type, Print) (Wife) 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Method of Disposition (Name of Disposition ( |              |
| 19a. Informant's Name/Relationship (Type, Print) (Wife) 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Method of Disposition (Name of Disposition ( |              |
| 19a. Informant's Name/Relationship (Type, Print) (Wife)  19a. Informant's Name/Relationship (Type, Print) (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type, Print) (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type, Print) (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  20b. Place of Disposition (Name of Date 20c. Location of City or Town, State, Zip Code)   |              |
| 19a. Informant's Name/Relationship (Type, Print) (Wife)  19a. Informant's Name/Relationship (Type, Print) (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type, Print) (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type, Print) (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  20b. Place of Disposition (Name of Date 20c. Location of City or Town, State, Zip Code)   |              |
| 19a. Informant's Name/Relationship (Type, Print) (Wife)  19a. Informant's Name/Relationship (Type, Print) (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type, Print) (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19a. Informant's Name/Relationship (Type, Print) (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  20b. Place of Disposition (Name of Date 20c. Location of City or Town, State, Zip Code)   |              |
| Mrs. Carol Hungerford Windsor 460 Oklahoma Ave., Sykesville, MD 21784  |              |
| 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory of other place)   |              |
| U W E   W Burial 2   Cremation 3   Removal from State  |              |
| E & § g g g g g g g g g g g g g g g g g g  |              |
| Sykesville, MD 21784 (410)-795-1400  |              |
| 23a. Part1. Enter the disease, or complications that/caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death   |              |
|  | -5           |
| Examiner  Sequentially list conditions  D. Sedicis  4. Time of   | h_           |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):   |              |
| Illicate be e edical E edical E edical E   |              |
|  |              |
| FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 5   Other (specify)   23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   9   Unknown   9   Unknown   1   Ves 2   No 3   Probably 4   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day Year   Mont   |              |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?   | ,            |
| 1   Yes 2   No 3   Probably 4   Unknown  | wn           |
| 1   Yes 2   No 3   Probably 4   Unknown of cause of the completion of the completion of the c | ble<br>of    |
|  |              |
| Tellipatient 202 Proutpatient 30 DOA 40 Nursing Home 50 Hesidence 6 Other (Specify)  |              |
| 27. Manner of Death 28a. Date of Injury 28b. Time of 1. Natural 5 Pending (Month, Day Year) 28b. Time of 1. Natural 5 Pending investigation 28c. Injury at Work? 1 Pes 2 No  |              |
| 2 Recident  2 Recident  3 Suicide  3 Suicide  4 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, page 1)  |              |
| 29a. Certiflier (Check only (C |              |
| 29a. Certifler (Check only one)  29a. Certifler (Check only one)  29a. Certifler (Check only one)  29b. Signature and title of certifler (29b. Signature and title of certifler)  29b. Signature and title of certifler (29c. License number)  29c. License number (29d. Date signed (Month, Day, Year)  |              |
| Paul Barney MD NO 060335 July 20, 2006   |              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |              |
| State 31. Date filed (Month, Day, Year) 32. Polistrar's Signature  |              |
| Registrar JUL 2 1 2006 Back & Breeks   |              |
| DHMH 17 Rev 1/2001  ORIGINAL   |              |

|  |  |                  | -   | State of Maryland   | d / Departm                            | ent of Health and  | Mental Hygi                              | ene                           |                                 |
|--|--|------------------|---|---|--|--|--|-------------------------------|---------------------------------|
|  |  | •                | For<br>State<br>Registrar   | ,   |  | ate of Death   |  | g. No2 0 0 6                  | 22950                           |
|  |  |                  | 1. Decedent's Name (First, Middle, Last)                                      |   |  |  | 2. Date of Death<br>Month                | Day Year                      | 3. Time of Death                |
|  | Physicia<br>Medic/   |                  | PAUL JUSI   | EPH WEL   | SH, J                                  | R  | July                                     | 19 2006                       | 4.50P. M                        |
|  | Examin   | er               | 4a. Facility Name (If not institution, give s                                 |   | 4b. C                                  | tity, Town, or Location of Des   | ath /                                    | 4c. County of Dea             | th A                            |
|  |  |                  | 5. Social Security Number 6. Sex  | DRIVE<br>7. Age (In yrs. II   | ast birthday) If Ur                    | der 1 Year   If Under 24 Hi  | 8. Date of Birth<br>(Month, Day,         | 9. Bir                        | thplace (State or Foreign       |
|  | uneral<br>rector   |                  |   | M 2□F 5   | Yrs. Mont                              | hs Days Hours Mi   | n. (Month, Day,                          | 1950 Pen                      | nsy Ivania                      |
| pu   | 2  |                  | Usual Residence of Decedent  10a. State 10b. County                           | 10c City  | , Town or Location                     |  |  |                               | 10d. Inside City Limits         |
| Maryla   | f sho  | 5                | MD Hacks  | cd  | Roll                                   |  |  |                               | 1 □ Yes 2 No                    |
| the  | r 28e-   | rect             | 10e. Street and Number  | Y.Cl  | 101                                    | Zip Code   | 10                                       | g. Citizen of What Co         | ountry?                         |
| th with  | 23e o  | Funeral Director | 238 Drexel  | Drive.  |  | 21014  |  | USA                           |                                 |
| ar dea   | tems   | uner             | 11. Marital Otatas  | 12. Was Decedent Ever in U.<br>Armed Forces?  | S. 13. Was D                           | ecedent of Hispanic Origin?<br>specify Cuban, Mexican, Pu  | (Specify Yes or No-<br>erto Rican, etc.) | 14. Race · Ame<br>Black, Whit |                                 |
| is aft   | II, or   | by F             | 1 Never Married 2 Married 3 Widowed 4 Divorced                                | 1 M Yes 2 □ No<br>If Yes, Give<br>Year or Dates:                                    | 1□ Ye                                  | s 2 No Specify:  |  | Specify:                      | rite                            |
| at yiailid ZiZi3>0030<br>should be filed within 72 hours after death with the Maryland<br>nd Mental Hydiene. | ical E   | ted              | 15. Decedent's Edu<br>(Specify only highest grade                             | cation  | 16a. Decedent's l                      | Isual Occupation   | varkina 1                                | 6b. Kind of Business          | /Industry                       |
| ithin of   | hen "r   | Completed        | Elementary/Secondary (0-12)   | Callege (1-4or 5+)  | `life. DO NO                           | T use retired)   | 5g                                       | 505 -                         | Tag                             |
| N pelli  | thert<br>nt, th  |                  | 17. Father's Name (First, Middle, Last)                                       | <u>ا</u>  | Sale.                                  |  | ame (First, Middle, M                    | laiden Sumame)                | ruc.                            |
| 2 should be filed with   | ked o  | To Be            | Paul J. 11  | lolsh Sa  |  | Fou  | nces M                                   | annino                        |                                 |
| shou Mand M  | e mar  | -                | 19a. Informant's Name/Relationship (Ty  | ре, Print)  | 19b. Mailing Add                       | ress (Street and Number or I   |  |                               | ip Code)                        |
| and 2  | n 27 i<br>1er tre  |                  | Kelly Welsh -   | daughter  | 338 1                                  | rexel Driv   | c, bel Ai                                | r MD .                        | 21014.                          |
| Pages 1  | If iter<br>or oth  |                  | 20a. Method of Disposition 1 ☐ Burial 2 🙇 Cremation 3 ☐ P                     | lemoval from State  | lace of Disposition emetery, crematory | or other place)  | -Date 2                                  | Oc. Location - City or        | Town, State                     |
| DAILLING  Dermit. Pages  Department of   | Importent: If item 27 is marked other then "natural", or Items 23e or 28e-f show eny injury or other treumetic event, the Madical Examiner must be notified at once. |                  | * 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Lighns   |   | US TUNCIA                              | I (No fel D) HTT<br>a and Ad ress of Facility  | 7/120/06                                 | POPESTI                       | 711 MD                          |
| permit.  | eny ir   |                  | Kulyela V   | Sulpatus  | FUNA                                   | S Funoral Chi  | not-ful                                  | Air Fores                     | of Hill the                     |
| 548  |  |                  | 23a. Part1. Enter the disease, ir complishock, or heart failure. Lift only or | icallor's that caused the death   | n. Do not enter the                    | mode of dying, such as card  | ac or respiratory arre                   |                               | Approximate<br>Interval Between |
| Phy  | sician   |                  | Immediate Cause (Final disease or condition                                   | Ca  | Tonque                                 | •  |  |                               | Onset and Death                 |
|  | edical<br>miner  |                  | resulting in death)   | Due to (or as a consequ   |  |  |  |                               |                                 |
|  | 3-1  | ē                | if any, leading to immediate  | Due to (or as a consequ   | uence of):                             |  |  |                               |                                 |
| petus /  | ransit   | Examiner         | cause. Enter Underlying Cause (Ulesause or Injury) that initiated events      |   |  |  |  |                               |                                 |
| 6 be exe   | hysicien and the burial-transit  | i Ex             | resulting in death) Last  | Due to (or as a consequ   | uence of):                             |  |  |                               |                                 |
| The law requires that the death certificate be executed.   | physic<br>s the b  | dicai            |   | i   |  |  |  |                               |                                 |
| Centif   | nding<br>use at  | n/Me             | IF FEMALE: 23b. Was decedent pregnant   | 3c. If yes, outcome of pregna   |  |  |  | 23d. Date of de               | livery                          |
| death death  | been signed by the attending pt<br>should be detached for use as t   | Physician/Med    | in the past 12 months?<br>1 ☐ Yes 2 ☐ No                                      | 1 Live birth 2 Fetal 4 Pregnant at time of de                                       |  | ic pregnancy<br>(specify)  |  | Month                         | Day Year                        |
| i the C  | d by the   | Phys             | 9 Unknown   |   |  | an anna anna in Bart I   | 22a Did tohi                             | acco use contribute to        | the cause of death?             |
| ires t   | signe<br>d be d  | by               | Part II. Other significant conditions con                                     | remound to death but not rest   | линд и ине иноенун                     | ng cause given in Fait i.  | and a                                    |                               | robably 4 Unknown               |
| COLOS<br>w requires  | peen   | mpleted          |   |   |  |  | 24a. Was an                              | 24b. Were a                   | utopsy findings available       |
| The la   | page 2   | Comp             |   |   | *                                      |  | autopsy perform                          | ed? death?                    | completion of cause of          |
|  | is certificate has t<br>director, page 2 s   | BeC              | 25. Was case referred to medical examiner?                                    |   |  | 26. Place of D   | eath (Check only one                     | 1                             |                                 |
| OI V<br>Physic   | E E  | ဥ                | 1 ☐ Yes 2 No  |   |  | The second secon | Home 5 X Resider                         |                               | cify)                           |
| SION (tending fact)  | After  | tion             | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation             | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury                 | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No  | Zod. Describe not                        | w injury occurred             |                                 |
| JIVISION OF VITA or Attending Physician: ifter death.  | ector:<br>by the   | ertification:    | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At he building, etc. (Specify                                |  | ctory, office  | 28f. Location (Str.<br>City or Town,     | eet and Number or R<br>State) | ural Route Number,              |
| Ital or  | led in   | O                | Tomore  | building, old. (opour)  |  |  |  |                               |                                 |
| DIVISION To the Hospital or Attendition 24 hours after death   | To the Funeral Dir<br>completely filled in   | edical           |   | sician: To the best of my kno<br>ner: On the basis of examina<br>and manner stated. |  |  |  |                               |                                 |
| To the   | o the  | Med              | 29b. Signature and title of certifier   |   |  | 29c. License number  | 7 29                                     | d. Date signed (Mont          | h, Day, Year)                   |
| F= 5   | 0  |                  |   |   |  | 01249  |  | 7/2/100                       |                                 |
| £C   | 14   |                  | 30. Name and address of person who co   | ompleted cause of death (Item   | 23a) (Type, Print)                     | - 81000  | 0 - 0                                    | 110                           |                                 |
| 10   | , 1  |                  | 31. Date filed (Month, Day, Year)   | 607 S<br>Registrar's Signa  | ATWOD<br>ture                          | D ROVED  | BEC AI                                   | K MI)                         | 21014                           |
| 4  | Sta<br>Registi   |                  | 1111 2. 1 2006  | 32 Registrar's Signa  | : Sparle                               | ,  |  |                               | /                               |

#### 06-05056

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Aleksander Wojtkiewicz 1- For State Certificate of Death Rea No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1810 hrs July 14, 2006 Medical Examiner Aleksander Wojtkiewicz 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (if not institution, give street and number) **Baltimore City** Saint Agnes Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) 9 Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Foreign Days Min Months Hours Director Country) 1 XM 2 43 15 1963 218-63-0758 Latvia Usual Residence of Decedent 10d Inside City Limits iny 10b. County 10c. City, Town or Location 1 Yes 2 XNo items 23a or 28a-f show MD Baltimore Halethorpe notified at once. death with the Maryland Director 10g Citizen of What Country 10f. Zip Code 10e. Street and Number 4813 Fernley Square 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces? White, etc. Yes Yes 2 X No specify: Yes, Give Year Specify: White Widowed Divorced Pages I and 2 should be filed within 72 hours after tent of Health and Mental Hygiene ant: If item 27 is marked other than "natural", ro other traumatic event, the Medical Examinet. 2 16a Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 5+ International Grand Master 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Pawel Wojtkiewicz Tamara Voitkevica Be 19a Informant's Name/Relationship (Type Definit) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4813 Fernley Square Halethorne, MD 21227

Date 120c Location - City or Town, State Amber Berglund/ P<u>artner</u> 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) Removal from Stat 1 Burial 2 X Cremation 3 Important: injury or oth 7/18/06 Baltimore, MD Metro Crematory, Inc. Donation 5 Other Specify 21. Signature of Funeral Service Ltd. Todd Dring <sup>22</sup>Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on Between Onset and /Medical Death a gastrointestinal bleeding due to cirrhosis of liver Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and, Physician/Medical AMENDED UNPENDED attending physician or use as the burial of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b Were autopsy findings available certificate has been prior to completion of cause of autopsy performed? death? page 2 No ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death 25. Was case referred to medical Be examiner? Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 🗸 Yes ٩ 28d Describe how injury occurred 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 8c. Injury at Work? After 27. Manner of Death Certification: 1 V Natural Division Yes 2 Pending within 24 hours after death To the Funeral Director: 2 \_ Accident Investigation filled in by 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. July 15, 2006 William 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD Assistant Medical Examiner

State

OCME 2006

Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

**ORIGINAL** 

strar's Signature

|   | 1            | For<br>State<br>Registrar  |                                      | State                       | of Maryl                                    | and / Dep                           | artmen<br>rtificate                       |                        |                                     | ind M                     |   | gienę<br>Reg. Nó |                                  | 6                                    | 22952   |
|---|--------------|--|--------------------------------------|-----------------------------|---|-------------------------------------|---|------------------------|-------------------------------------|---------------------------|---|------------------|----------------------------------|--------------------------------------|---|
| Physician   | _            | I. Decedent's Name   | (First, Middle, L                    | .ast)                       |   |                                     |   |                        |                                     |                           | 2. Date of De.<br>Month                 | ath<br>Da        | , Y                              | ear                                  | 3. Time of Death                                    |
| Physician<br>/Medical   | L            | John X.  |                                      |                             |   |                                     | 1   |                        |                                     |                           | 07                                      | 08               | 2006                             |                                      | 5:45p M   |
| Examiner  | 1            | a. Facility Name (If   | _                                    |                             | iumber)                                     |                                     | 1   | ckvi                   | Location o                          | t Death                   |   |                  | County of Mont 2                 |                                      | 227   |
|   | 5            | 757 Azal   |                                      | e<br>Sex                    | 7. Age (In                                  | vrs. last birthday                  |   |                        | If Under:                           |                           | 8. Date of Birt                         |                  |                                  | . Birthr                             | place (State or Foreign                             |
| Funeral<br>Director   |              | 141-20-5   |                                      | 1 <b>™</b> M 2□F            | 80  | yrs. last birthday<br>Yrs.          | Months                                    | Days                   | Hours                               | Min.                      | 8. Date of Bird<br>(Month, Da<br>04-21- | 1926             |                                  | New                                  | Jersey  |
| p <sub>e</sub>  | -            | Jsual Residence of I   | Decedent                             |                             | 100   | . City, Town or L                   | ocation.                                  |                        |                                     |                           |   |                  |                                  | 1                                    | 10d. Inside City Limits                             |
| aryia<br>shov   |              | MD State   | 10b. County  Mont                    | gomery                      | 100   | Rockv:                              |   |                        |                                     |                           |   |                  |                                  |                                      | YEYes 2 □ No  |
| the M   | 3            | 10e. Street and Num  | ber                                  |                             |   |                                     | 10f, Zip                                  | Code                   |                                     |                           |   | 10g. Cit         | izen of Wha                      | at Cour                              | ntry?   |
| 3a or   |              | 757 Azal   |                                      | e                           |   |                                     |   | 2                      | 20850                               |                           |   |                  | USA                              |                                      |   |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show may highly or other traumatic event, the Medical Examinar must be notified at once.  To Re Completed by Funeral Director | and a second | 11. Marital Status 1 Never Marrie 3 Widowed  |                                      | Armed                       | Give  | in U.S. 13.                         | Was Deced<br>If Yes, spec                 |                        | ispanic Origin, Mexican<br>Specify: | gin? (Spo<br>I, Puerto    | ecify Yes or No<br>Rican, etc.)         |                  | 14. Race -<br>Black,<br>Specify: |                                      | etc.  |
| 5-0<br>72 hg  |              | (Specil  | 15. Decedent's<br>fy only highest of | Education<br>grade complete | d)  | 16a. Dece<br>(Giv                   | edent's Usua<br>e kind of wo<br>DO NOT us | al Decupa<br>nk done d | ation<br>during most                | t of work                 | ing                                     | 16b. K           | ind of Busin                     | ness/In                              | dustry  |
| within then then then then then then then the   |              | Elementary/Secon   | idary (0-12)                         | College<br>5                | (1-4or 5+)                                  |                                     | ager                                      | se retirea             | )                                   |                           |   | N                | ewspa                            | per                                  |   |
| d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2   | 3            | 17. Father's Name (F   | First, Middle, La                    | st)                         |   |                                     |   |                        |                                     |                           | e (First, Middle,                       | Maiden           | Sumame)                          |                                      |   |
| yland be fill Mental Hyarked oth attic even   | 2            | Patrick  | Ward                                 |                             |   |                                     |   |                        | G <sub>1</sub>                      | race                      | Kelly                                   |                  |                                  |                                      |   |
| Maryland and 2 should be file alth and Mental Hy 27 is marked oth artraumatic event   |              | 19a. Informant's Nai<br>Flora Wa   | me/Relationship<br>ird/wife          | (Type, Print)               |   | 19b. Maii<br>757                    | ing Address<br>Azale                      | (Street a              | Rocand Number                       | r or Aura<br>Ck <b>vi</b> | lle, MD                                 | 208              | 50 St.                           | ate, Zip                             | Code)   |
| Baltimore, semil. Pages 1 ar Department of Hear mportant: If Item any Injury or othe page.  | -            | 20a. Method of Dispo<br>1 ☐ Burial 2 🛣   |                                      | □Removal fro                |   | Ob. Place of Disp<br>cemetery, cre  | ematory or o                              | ther plac              |                                     |                           | Date                                    |                  | ocation - Ci                     |                                      |   |
| Lime<br>Pag<br>Iment<br>tant: Jury o  |              | 4 Donation   | 5 Other (Spe                         | city)                       | 5.0.0                                       | Chesape                             |   |                        |                                     |                           | 12-2006                                 |                  | 1tsvi                            |                                      | e, MD   |
| Ball<br>permit<br>Depar<br>Impor<br>any In  |              | 21. Signature of Fur   |                                      | ) (                         | ······                                      | I                                   | 933                                       | Gist                   | : Ave                               | Sil                       | rematio<br>ver Spr                      | ing              | rvice<br>MD 20                   | 910                                  |   |
| Physician   |              | Immediate Cause (F   | t failure. List on<br>Final          | ly one cause or             | n each line.                                | on Pneu                             |   | e of dyin              | g, such as                          | cardiac                   | or respiratory a                        | rrest,           |                                  |                                      | Approximate Interval Between Onset and Death 3 days |
| /Medical<br>Examiner  |              | resulting in death)  | 1                                    | _                           |   | nsequence of):                      |   |                        |                                     |                           |   |                  |                                  |                                      | years   |
|   |              | Sequentially list con  | nditions,                            | b                           | mentia<br>to (or as a co                    | rsequence of):                      |   |                        |                                     |                           |   |                  |                                  |                                      | years   |
| 3760, ate be executed hysician and he burial-transit  |              | Sequentially list con<br>if any, leading to min<br>cause. Enter Under<br>Cause (Disease or in<br>that initiated events | tying<br>njury                       |                             |   |                                     |   |                        |                                     |                           |   |                  |                                  |                                      |   |
| 60, be executed ician and burial-transit  |              | resulting in death) L  | ast                                  | Due                         | to (or as a cor                             | nsequence of):                      |   |                        |                                     |                           |   |                  |                                  |                                      |   |
| ate be ex<br>hysician<br>the burial   |              |  | •                                    | d.                          |   |                                     |   |                        |                                     |                           |   |                  |                                  | 4                                    |   |
| S, P.O. Box 68' es that the death certificat gened by the attending phy be deleched for use as th by Physician/Madil  | yaiciaining  | IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown  | months?                              | 1 Liv                       | outcome of president time but at time known | Fetal death 3                       | □Ectopic pi<br>□ Other (sp                |                        |                                     |                           |   |                  | 23d. Date of Month               |                                      | ery<br>Day Year                                     |
| ords, P.O. requires that the een signed by the nould be deteched  |              | Part II. Other signifi   | cant condition                       | s contributing to           | death but no                                | t resulting in the                  | underlying o                              | ause giv               | en in Part I                        |                           | 23e. Did t                              | obacco           | use contrib                      | ute to t                             | he cause of death?                                  |
| quires  | 2            |  |                                      |                             |   |                                     |   |                        |                                     |                           | 10                                      | Yes 2            | <b>⊠</b> No 3                    | ☐ Prol                               | bably 4 □Unknown                                    |
| Vital Records, sicien: The law requires to certificate has been signe rector, page 2 should be  | andino       |  |                                      |                             |   |                                     |   |                        |                                     |                           | 24a. Was<br>autor<br>perio              | psy<br>prmed?    | dea                              | re auto<br>or to co<br>oth?<br>] Yes | opsy findings available ompletion of cause of       |
| /ita  | ע            | 25. Was case referr examiner?  | ed to medical                        |                             |   |                                     |   | 1                      |                                     | of Deat                   | h (Check only o                         | опе)             |                                  |                                      |   |
| F Se Se F   | 2            | 1 ☐ Yes 2 🙀 !  |                                      |                             |   | 2 ER/Outpatio                       |   |                        | 4 1110                              | irsing Ho                 | me 5 Resi                               |                  |                                  |                                      | fy)   |
| Jing After fune   | 5            | 27. Manner of Death<br>1 X Natural   | 1<br>5 ☐ Pending<br>investiga        |                             | te of Injury<br>onth, Day Ye                | ar) 28b. Time<br>Injury             | or a                                      | 8c. Injur<br>Wor       | yat<br>k?<br>Yes 2. □               | No                        | 28d. Describe                           | now inju         | ry occurred                      |                                      |   |
| Division  or Attending after death. Director: Attention in by the fune  | 2            | 2 Accident 3 Suicide   | 6 Could no                           | t be 28e. Pla               | ce of Injury -                              | At home, farm, s                    |   |                        |                                     |                           |   |                  |                                  | or Rur                               | al Route Number,                                    |
| Division of tell or Attending P is after death.  el Director: After ted in by the funera  |              | 4 🗌 Homicide   | 40.0                                 | bu bu                       | ilding, etc. (S                             | pecify)                             |   |                        |                                     |                           | City or To                              | wn, State        | 9)                               |                                      |   |
| Hospl<br>4 hou<br>Funer<br>tely fill  | Medical      | 29a. Certifier<br>(Check only<br>one)  |                                      | aminer: On the              |   | y knowledge, dea<br>mination and/or |   |                        |                                     |                           |   |                  |                                  |                                      |   |
| To the within 2 To the complete   | M            | 29b. Signature and   | title of certifier                   | 3                           | _ W   | 10                                  | 29  |                        | e number<br>4216                    |                           |   | 29d. Da          | te signed <i>(</i>               | Month,<br>-20(                       | Day, Year)<br><b>)6</b>                             |
| 10  |              | 30. Name and addre   | ess of person w<br>Abris             | no completed canami MD      | ause of death                               | (Item 23a) (Type<br>E Darne         | e, Print)<br>stown                        | Rd.                    | Nort                                | h Po                      | tomac,                                  | MD 2             | 20878                            |                                      |   |
| State<br>Registra   |              | 31. Date filed (Mont   | JUL 2                                | 1 2005                      | . Registrar's                               | Signature                           | Spanie                                    | وع                     |                                     |                           |   |                  |                                  |                                      |   |

|                                |  |   | For State   | State of Marylan   | d / Department of F<br>Certificate of  |  |  | 4000   | 22953  |
|--------------------------------|--|---|---|--|--|--|--|--|--|
|                                |  |   | Registrar  1. Decedent's Name (First, Middle, Last)   |  | Certificate of   | 2.0  | Reg. No  | lo.  | 3. Time of Death   |
| п                              | Physicia   |   | MARYANA   | WATK!  | NS   | 7'   | Month  | 2006   | 10:52 AM   |
|                                | /Medic<br>Examin   |   | 4a. Facility Name (If not institution, give s   | street and number)   |  | Location of Death  | 0 4  | c. County of Death   |  |
|                                |  |   | HARBOR  | HOSPITAL   | last birthday) If Under 1 Year   | TIMORE If Under 24 Hrs. 8. 6   | The set Birth  | 0.814  | (0)  |
| T                              | Funeral Director   |   | 5. Social Security Number 6. Sex  | 7. Age (In yrs.  | Yrs. Months Days   | Hours Min. (   | Date of Birth<br>Month, Day, Yea   |  |  |
|                                |  |   | 215-28-4198 Usual Residence of Decedent   | 74   |  |  | ne 6, 19   |  |  |
|                                | arylan<br>show   | <u>.</u>  | 10a. State 10b. County Maryland Baltimore   |  | y, Town or Location<br>lethorpe  |  |  | 1  | 10d. Inside City Limits  |
|                                | 28a-f  | ecto  | 10e. Street and Number  | Tid.   | 10f. Zip Code  |  | 100.0  | Citizen of What Cour   | 1 Yes 2 No   |
|                                | with I   | Funeral Director                                    | 2714 Norfen Road  |  | 21227  |  | USZ  |  | nu y :   |
|                                | death  | nera  |   | 12. Was Decedent Ever in U.<br>Armed Forces?   | .S. 13. Was Decedent of H  | ispanic Origin? (Specify<br>In, Mexican, Puerto Rica                     | Yes or No-   | 14. Race - Americ<br>Black, White,   |  |
| 98                             | or Its   | y Fu  | 1 Never Married 2 Married   | 1 ☐ Yes 2 ☐ No<br>If Yes, Give   | 1 Yes 2 No   | Specify:   | 11, 010.7  | Specify:   |  |
| Ö                              | hours<br>turel',   | ed by   | 3- Widowed 4 □ Divorced  15. Decedent's Edu   | Year or Dates:   | 16a. Decedent's Usual Occur  | ation  | 16b  | Kind of Business/In-   | hite<br>dustry   |
| 7                              | nin 72<br>n "na<br>Medic   | plet  | (Specify only highest grade   |  | (Give kind of work done<br>life. DO NOT use retired  | during most of working   | 100.   | Turis of Basilossiii.  | Gustry   |
| 212                            | ad with  | Completed   | 12  |  | Homemaker  |  |  | Own Home   |  |
| ind                            | ould be filed within 72 hours after death with the Maryland<br>Mental Hygiene.<br>Arted other then "natural", or items 23a or 28a-f show<br>arted other then "natural", or items 23a or 28a-f show<br>arte event, the Madical Exeminar must be notified at   | Be  | 17. Father's Name (First, Middle, Last)   |  |  | 18. Mother's Name (Fir<br>Marie Kohl                                     |  | en Sumame)   |  |
| <u>2</u>                       | should<br>and Men<br>marke<br>umatic   | <u>ئ</u>  | Edward Berger  19a. Informant's Name/Relationship (Ty   | ne Print)  | 19b. Mailing Address (Street   |  |  | or Town State Zin  | Code)  |
|                                | end 2 s<br>ealth en<br>n 27 is r   |   | Robert Watkins- so  | •  | 8125 R Hickory   |  |  |  |  |
|                                | s 1 er   |   | 20a. Method of Disposition  | 1 ^  | Place of Disposition (Name of commetery, crematory or other place  | Date   | 20c.   | Location - City or To  | own, State   |
| <u>=</u>                       | Pages<br>ment of I<br>ant: If Its<br>ury or o  |   | 1 Burial 2 ☐ Cremation 3 ☐ R<br>4 ☐ Donation 5 ☐ Other (Specify)  | lemoval from State   | bwridge Memorial F   | ark 7/13/20  |  | ridge, MD  |  |
| Baltimore,                     | permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Proportent: if Item 27 is marked other than "naturel; or Items 23a or 28a-f show eny injury or other treumatic event, the Macilical Examinar must be notified at Apprex.  Once. |   | 21. Signature of Funeral Service License  | 88   | 22. Name and Addre<br>Gary L. Ka   | ss of Facility<br>Iufman Funer   | al Home  | at MMP,  | Inc.   |
|                                | 40204  |   | 23a. Part1. Enter the disease, or compli  | ications that caused the deat  | 7250 Wash:   | <u>ngton Blvd.</u>   | , Elkric   | dge, MD 2  | 1075<br>Approximate  |
|                                | Physician  |   | shock, or heart failure. List only or<br>immediate Cause (Final   | ne cause on each line.   |  |  |  | DICEAG   | Interval Between<br>Onset and Death  |
| 1                              | /Medical   |   | disease or condition resulting in death)  | Due to (or as a conseq   | OBSTRUCTI  | VE PULIT   | UNTER  | ייייייייייייייייייייייייייייייייייייייי  |  |
|                                | Examiner   |   | Sequentially list conditions,   | PNEUMO   | NIA  |  |  |  | 4 DAYS   |
|                                |  |   |   | J  |  |  |  |  | 0/123  |
| /                              | ed<br>sit  | ılner   | if any, leading to immediate cause. Enter Underlying  | Due to (or as a consequence  |  |  |  |  | 07123  |
| 1                              | executed<br>n and<br>al-transit  | Examiner  | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | J  | uence of):   |  |  |  | 0/11/2   |
| 760,                           | te be executed<br>ysticien and<br>te burial-transit  | cal Examiner  | if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events   | Due to (or as a consequence  | uence of):   |  |  |  | V/1 ( 3  |
| C 68760, C                     | sriticate be executed<br>ing physicien and<br>e as the burial-transit  | dical   | if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last  | Due to (or as a consequence of the consequence of t | uence of):<br>uence of):   |  |  |  | 717.3  |
| Box 68760,                     | asth certificate be executed attending physicien and for use as the burial-transit   | dical   | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  | Due to (or as a consequence of  | uence of):  uence of):  ancy  I death 3 □Ectopic pregnance   | ,  |  | 23d. Date of deliver   |  |
| .O. Box 68760, <               | the death certificate be executed<br>y the attending physicien and<br>iched for use as the burial-transit  | dical   | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant  | Due to (or as a consequence of the consequence of t | uence of):  uence of):  ancy  I death 3 □Ectopic pregnance   | ,  |  |  | ery  |
| s, P.O. Box 68760, <           | s that the death certificate be executed ined by the attending physicien and detached for use as the burial-transit  | dical   | if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No   | Due to (or as a consequence of the consequence of t | uence of):  uence of):  ancy I death 3   Ectopic pregnance leath 5   Other (specify)   |  | 23e. Did tobacco   |  | ery<br>Day Year  |
| ords, P.O. Box 68760, <        | equires that the death certificate be executed<br>en signed by the attending physicien and<br>ould be detached for use as the burial-transit   | by Physician/Medical                                | if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 100 Unknown   | Due to (or as a consequence of the consequence of t | uence of):  uence of):  ancy I death 3   Ectopic pregnance leath 5   Other (specify)   |  | 23e. Did tobacco<br>1 □ Yes  | Month  o use contribute to the   | ery<br>Day Year  |
| lecords, P.O. Box 68760, <     | w requires that the death certif<br>been signed by the attending<br>should be detached for use as  | by Physician/Medical                                | if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 100 Unknown   | Due to (or as a consequence of the consequence of t | uence of):  uence of):  ancy I death 3   Ectopic pregnance leath 5   Other (specify)   | en in Part I.  | 1 ☐ Yes  | Month  b use contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to contribute to the contribute to contribut | ery<br>Day Year<br>he cause of death?  |
| al Records, P.O. Box 68760, <  | w requires that the death certif<br>been signed by the attending<br>should be detached for use as  | Completed by Physician/Medical                      | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence of the consequence of t | uence of):  uence of):  ancy I death 3   Ectopic pregnance leath 5   Other (specify)   | en in Part I.  | 1 Yes  24a. Was an autopsy performed? 1 Yes 2 8  | Month  o use contribute to the contribute to the contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to contribute t  | ery Day Year he cause of death? bably 4 Unknown bopsy findings available impletion of cause of   |
| Vital Records, P.O. Box 68760, | w requires that the death certif<br>been signed by the attending<br>should be detached for use as  | Be Completed by Physician/Medical                   | if any, leading to deriving cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or as a consequence of the consequence of t | uence of):  uence of):  ancy I death 3 □Ectopic pregnancy leath 5 □ Other (specify) □  | en in Part I.  26. Place of Death (Ch                                    | 1 Yes  24a. Was an autopsy performed? 1 Yes 2550   | Month  Do use contribute to the contribute to the contribute to contribute to the co | ery Day Year  he cause of death?  bably 4 Unknown  posy findings available indicates of the cause of the caus |
| of Vita                        | w requires that the death certif<br>been signed by the attending<br>should be detached for use as  | To Be Completed by Physician/Medical                | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence of the consequence of t | uence of):  uence of):  ancy I death 3   Ectopic pregnance leath 5   Other (specify)    ulting in the underlying cause given  IER/Outpatient 3   DOA   Other   | en in Part I.  26. Place of Death Cher: 4 \( \) Nursing Home             | 1 Yes  24a. Was an autopsy performed? 1 Yes 2550   | Month  Do use contribute to th | ery Day Year  he cause of death?  bably 4 Unknown  posy findings available indicates of the cause of the caus |
| of Vita                        | w requires that the death certif<br>been signed by the attending<br>should be detached for use as  | To Be Completed by Physician/Medical                | if any, leading to a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence of the consequence of t | uence of):  uence of):  uence of):  uency I death 3   Ectopic pregnance I eath 5   Other (specify)    ulting in the underlying cause gradulting in the under | en in Part I.  26. Place of Death Cher: 4 \( \) Nursing Home             | 1   Yes  24a. Was an autopsy performed? 1   Yes 2 25 \( \)  1   Yes 2 5 \( \)  1   Residence                           | Month  Do use contribute to th | ery Day Year  he cause of death?  bably 4 Unknown  posy findings available indicates of the cause of the caus |
| of Vita                        | w requires that the death certif<br>been signed by the attending<br>should be detached for use as  | To Be Completed by Physician/Medical                | if any, leading to deriving cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 50 Unknown  Part II. Other significant conditions | Due to (or as a consequence of the consequence of t | uence of):  uence  | en in Part I.  26. Place of Death Cher: 4 Nursing Home yat 28d. Yes 2 No | 1   Yes  24a. Was an autopsy performed? 1   Yes 2 25 Areck only one) 5   Residence Describe how inj                    | Month  Do use contribute to th | ery Day Year  he cause of death?  bably 4 Unknown  posy findings available impletion of cause of 2 No  |
| of Vita                        | w requires that the death certif<br>been signed by the attending<br>should be detached for use as  | Certification; To Be Completed by Physician/Medical | if any, leading to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence of the consequence of t | uence of):  uence  | en in Part I.  26. Place of Death Cher: 4 Nursing Home y at k? Yes 2 No  | 1 Yes  24a. Was an autopsy performed? 1 Yes 2 36.  10 Residence Describe how inj  Location (Street a City or Town, Sta | Month  Do use contribute to the contribute to the contribute to the prior to condeath?  1  Yes  6  Other (Specification of Auralite)   | eny Day Year  the cause of death?  pably 4 Unknown  posy findings available impletion of cause of 2 No  ty)  |
| of Vita                        | w requires that the death certif<br>been signed by the attending<br>should be detached for use as  | Certification; To Be Completed by Physician/Medical | if any, leading to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence of the consequence of t | uence of):  uence  | en in Part I.  26. Place of Death Cher: 4 Nursing Home y at k? Yes 2 No  | 1 Yes  24a. Was an autopsy performed? 1 Yes 2 36.  10 Residence Describe how inj  Location (Street a City or Town, Sta | Month  Do use contribute to the contribute to the contribute to the prior to condeath?  1  Yes  6  Other (Specification of Auralite)   | eny Day Year  the cause of death?  pably 4 Unknown  posy findings available impletion of cause of 2 No  ty)  |
| of Vita                        | The law requires that the death certif<br>sie hes been signed by the attending<br>page 2 should be detached for use a  | Certification; To Be Completed by Physician/Medical | if any, leading to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence of the consequence of t | uence of):  uence  | en in Part I.  26. Place of Death Cher: 4 Nursing Home y at k? Yes 2 No  | 1 Yes  24a. Was an autopsy performed? 1 Yes 2 36.  10 Residence Describe how inj  Location (Street a City or Town, Sta | Month  Do use contribute to the contribute to the contribute to the prior to condeath?  1  Yes  6  Other (Specification of Auralite)   | eny Day Year  the cause of death?  pably 4 Unknown  posy findings available impletion of cause of 2 No  ty)  |
| of Vita                        | w requires that the death certif<br>been signed by the attending<br>should be detached for use as  | Certification; To Be Completed by Physician/Medical | if any, leading to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence of the consequence of t | uence of):  uence  | en in Part I.  26. Place of Death Cher: 4 Nursing Home y at k? Yes 2 No  | 1 Yes  24a. Was an autopsy performed? 1 Yes 2 36.  10 Residence Describe how inj  Location (Street a City or Town, Sta | Month  Do use contribute to the contribute to the contribute to the prior to condeath?  1  Yes  6  Other (Specification of Auralite)   | eny Day Year  the cause of death?  pably 4 Unknown  posy findings available impletion of cause of 2 No  ty)  |
| of Vita                        | w requires that the death certif<br>been signed by the attending<br>should be detached for use as  | Certification; To Be Completed by Physician/Medical | if any, leading to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence of the consequence of t | uence of):  uence  | en in Part I.  26. Place of Death Cher: 4 Nursing Home y at k? Yes 2 No  | 1 Yes  24a. Was an autopsy performed? 1 Yes 2 36.  10 Residence Describe how inj  Location (Street a City or Town, Sta | Month  Do use contribute to the contribute to the contribute to the prior to condeath?  1  Yes  6  Other (Specification of Auralite)   | eny Day Year  the cause of death?  pably 4 Unknown  posy findings available impletion of cause of 2 No  ty)  |
| of Vita                        | To the Mospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as   | Certification; To Be Completed by Physician/Medical | if any, leading to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | Due to (or as a consequence of the consequence of t | uence of):  uence  | en in Part I.  26. Place of Death Cher: 4 Nursing Home y at k? Yes 2 No  | 1 Yes  24a. Was an autopsy performed? 1 Yes 2 36.  10 Residence Describe how inj  Location (Street a City or Town, Sta | Month  Do use contribute to the contribute to the contribute to the prior to condeath?  1  Yes  6  Other (Specification of Auralite)   | eny Day Year  the cause of death?  pably 4 Unknown  posy findings available impletion of cause of 2 No  ty)  |

|                |   |                     | 1 - For State of M  | Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 0 6 2 2 9 5  | 7 14             |
|----------------|---|---------------------|---|---|------------------|
| e              | 2 11 2  |                     | 1. Decedent's Name (First, Middle, Last)  1. Decedent's Name (First, Middle, Last)  | 2. Date of Death 3. Time of De  | eath             |
|                | Physicia<br>/Medic  |                     | AlbERTA FRAN  | ICES WOODBURN July 19, 2006 5:39  | AM               |
|                | Examin  |                     | 4a. Facility Name (If not institution, give street and number 3612 HoFFMAN M  | 1111 Rd HAMPSTEAD CARROLL COUNTY OF DEATH CARROLL COUNTY OF DEATH CARROLL COUNTY OF DEATH   | Ty               |
|                | Funeral<br>Director   |                     | 28005-7180 10M 10F  | Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)  Yrs. Months Days Hours Min. SEPT. 25,1918  9. Birthplace (State or F  | -oreign          |
|                | land  |                     | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, Town or Location 10d. Inside City  | Limits           |
|                | e Mary  | ctor                | Md CARROll  | HAMPS TEAD 1 Tend   | Ν̈́ο             |
|                | th with th  | ai Dire             | 3612 HoFFMAN Mil  | 11 Rd 10f. Zip Code 2 10 74 10g. Citizen of What Country?   |                  |
| 5-0036         | 72 hours after death with the Maryland<br>"neturel", or Iteme 23s or 28s-f ehow<br>idical Examinet must be indiffed at  | by Funeral Director | 11. Marital Status  1 Never Married 2 Married  1 Widowed 4 Divorced  12. Was Deceder Armed Force 1 Yes, 23F Year or Date: | If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black, White, etc.  1 Yes a log Specify:   |                  |
| 21215-0        |   | Completed           | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c)                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Home Marker Marker  16b. Kind of Business/Industry  16b. Kind of Business/Industry   |                  |
| O              | be filed<br>ital Hygi<br>d other<br>event, I  | Be                  | 17. Father's Name (First, Middle, Last)  ALEWI  | 18. Mother's Name (First, Middle, Maiden Surname)   |                  |
| Marylan        | s 1 and 2 should<br>I Health and Men<br>Item 27 te marke<br>other traumatic   | ပ္                  | 19a Informant's Name/Relationship (Type Print)  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  N Sew 3612 HeFFMAN Mill Rd 21074   |                  |
| Baltimore,     | e = 5   |                     | 20a. Method of Disposition  Definial 2 Cremation 3 Removal from Sta  Donation 5 Other (Specify)                           | 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State   |                  |
| Balti          | permit. Par<br>Department<br>Important:<br>eny injury   |                     | 21. Signature of Funeral Service Licensee  Lanky M. Loew  | ner Eckhard Troveral Chapel owings h  | 1,115            |
| ×              | 70  |                     | 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on lach            | sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between  | en               |
|                | Physician<br>/Medical   |                     | Immediate Cause (Final disease or condition resulting in death)   | testatic lung CA Sum  | ath              |
|                | Examiner  |                     | Due to (or a  | as a consequence of):   |                  |
|                | ted<br>nsit   | niner               | cause. Enter Underlying<br>Cause (Disease or injury   | as a consequence of):   |                  |
| o,             | be executed<br>sician and<br>burial-transit   | Examin              | that initiated events c.  | as a consequence of):   |                  |
| 8760,          | cate be enthy sician  | dicai               | d.  |   |                  |
| .O. Box 6      | The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit | Physician/Me        |   | t at time of death 5 Other (specify) Month Day Yea  | ar               |
| ds, P          | luires that<br>n signed b   | þ                   | Part II. Other significant conditions contributing to death   | h but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of deal  1  Yes 2 70 3 Probably 4 Unk  |                  |
| Vital Records, | The law requinate the law requinate the law seems in page 2 should be   | Completed           |   | 24a. Was an autopsy prior to completion of cause performed?  1 Yes 2 1 Yes 2  | allable<br>se of |
| /ital          | ician: Th<br>certificate<br>rector, pag   | Bec                 | 25. Was case referred to medical examiner?  | 26. Place of Death (Check only one)   |                  |
| of/            | S S   | <br>T               | 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpa  27. Manger of Death 28a. Date of Ir  | atient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)  rjury 28b. Time of 28c. Injury at 28d. Describe how injury occurred   |                  |
|                | ding<br>After<br>fune   | ation               | 1 Natural 5 Pending (Month, I   | njury 28b. Time of 28c. Injury at Work?  M 1 1 Yes 2 No   |                  |
| Division       | i i i i i   | Certification:      | 3 Suicide 6 Could not be 28e. Place of  | Injury - At home, farm, street, factory, office etc. (Specify)  28f. Location (Street and Number or Rural Route Number etc. (Specify)   | <i>r</i> ,       |
|                | To the Hospital or At within 24 hours after of the Funeral Direct completely fitled in by   | edicai C            | 29a. Certifier Certifying Physician: To the be 2 Medical Examiner: On the basis and manner                                | ist of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  s of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) stated. |                  |
| )              | To ti<br>withii<br>comp   | Me                  | 29b. Signatule and title of certifier   | 29c. License number 29d. Date signed (Month, Day, Year) 7-20-06   |                  |
|                | 10  |                     | 30 Name and address of person to completed cause of FIAVIO Wuter mb 5   | of death (Item 23a) (Type, Print) 55 South Couter Street Westminster, HD 21157  |                  |
| 100            | Sta<br>Registr  |                     | 31. Date filed (Month, Day, Year) 32. Register 32. 1 2006   | of death (Item 23a) (Type, Print)  55 South Couter Street Wishmiuster, IMD 21157  istrar's Signature  Aparle  |                  |

|                |  |                | For<br>State<br>Registrar  | State of M  | •                                       | epartment of F<br>Certificate of   |  |   | Reg. No.                                     | 5 22955   |
|----------------|--|----------------|--|---|---|--|--|---|--|---|
|                | Physici<br>/Medic  |                | 1. Decedent's Name (First, Middle, Kenneth   | F. U  | Viles                                   |  |  | 2. Date of Dea<br>Month                       | Day 200                                      | 611:35 AM   |
|                | Examin   | er             | 4a. Facility Name (If not institution,   | General   |   |  | r Location of Dea                      |   | 4c. County of De                             | 2010  |
|                | Funeral<br>Director  |                | 216.36.4233 Usual Residence of Decedent  | 1 M 2□F   |   | Months Days  | Hours Min                              |   |  | Birthplace (State or Foreign<br>Country)  Maryland    |
|                | Aaryland<br>f show   | ō              | 10a. State 10b. County  Maryland   | Howard  | 10c. City, Town                         |  | llicott Clty                           |   |  | 10d. Inside City Limits 1 ☐ Yes 2 No                  |
|                | with the P<br>a or 28e-<br>be notif  | Director       | 10e. Street and Number   |   | <u> </u>                                | 10f. Zip Code  | 21042                                  |   | 10g. Citizen of What                         | Country?<br>J.S.A.                                    |
| 36             | be filed within 72 hours after death with the Maryland stal Hygiene. od other than "netural", or Items 23a or 28e-f show event, the Medical Examinar must be redified at | by Funeral     | 3337 N. Chatham R  11. Marital Status  1 Never Married 28 Marrie 3 Widowed 4 Divorced  | 12. Was Deceder<br>Armed Forces                               | No                                      | 13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No                        |  | (Specify Yes or No-<br>erto Rican, etc.)      |  | nerican Indian,                                       |
| 21215-0036     | I within 72 hou<br>liene.<br>r than "netura<br>The Medical E   | Completed      | 15. Decedent<br>(Specify only highest<br>Elementary/Secondary (0-12)<br>8th  |   |   | Decedent's Usual Occup<br>Give kind of work done<br>life. DO NOT use retired | during most of w                       | vorking                                       | 16b. Kind of Busines                         | ss/Industry<br>arpentry                               |
| Maryland 2     | should be filed<br>nd Mental Hygi<br>marked other<br>umatic event, I   | To Be C        |  | r Nelson Wiles  |   |  |  |   | er Leona Gree                                |   |
|                | ges 1 and 2 should<br>t of Health and Mer<br>If item 27 Is marke<br>or other traumatic   | - Landing      | 19a. Informant's Name/Relationsh  Ms. Betty Jo Wil   |   |   | Mailing Address (Street<br>3337 N. Chatl                                     |  |   | er, City or Town, State<br>t City, Maryland  |   |
| Baltimore,     | Pages 1 and of He  |                | 20a. Method of Disposition Burial 2 Cremation 4 Donation 5 Other (Sp   |   | e cemetery                              | Disposition (Name of crematory or other place                                |  | Date<br>07/17/2006                            | 20c. Location - City  Marriotts              | or Town, State ville, Maryland                        |
| Baltin         | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.   |                | 21. gnature of Fundal Service L  | ice ee  | 160535                                  | awn Memorial (<br>22. Name and Addre<br>Slack I<br>3871 (                    | ss of Facility<br>Funeral Hor          | ne. P.A.                                      | t City, MD 210                               | •   |
|                | Pnysician<br>/Medical<br>Examiner  | her            | 23a. Part1. Enter the disease, or shock, or heart failure. List of mediate Cause (Final ease or condition esulting in death)  Sequentially list conditions, if any, leading to introducing cause. Enter Underlying | aDue to (or a   | line.                                   | ot enter the mode of dyir  | ig, such as cardi                      | ac or respiratory ar                          | rest,  | Approximate Interval Between Onset and Death          |
| ,8760,         | death certificate be executed<br>e attending physician and<br>nd for use as the burial-transit   | dical Examine  | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last  | c. Sec<br>Due to (or a  | s a consequence of                      | NCCC.  |  |   |  | NO.   |
| .O. Box 6      | death certifi<br>e attending  <br>ed for use as  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  |   | 2 Fetal death<br>at time of death       | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _                                  | ,                                      |   | 23d. Date of o<br>Month                      | delivery<br>Day Year                                  |
| Δ.             | es tha   | by             | Part II. Other significant condition  Diabetes   | ns contributing to death                                      | 0 -1                                    | the underlying cause giv   | en in Part I.                          | 23e. Did to                                   | . /  | to the cause of death?  Probably 4 □Unknown           |
| Vital Records, |  | Completed      |  |   |   |  |  | 24a. Was<br>autop<br>perfo<br>1 \( \text{Yes} | prior t<br>rmed? prior t                     | autopsy findings available o completion of cause of ? |
| Vita           | Physician: T<br>this certificate<br>ral director, pa   | o Be           | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ₩ No   | Hospital:   | tient 2 ER/Out                          | patient 3 DOA Oth  | 05                                     | eath (Check only o                            | nne)<br>dence 6 □Other (S)                   | necify)   |
| ion of         | fter<br>ne   | $\vdash$       | 27. Manner of Death  1 Natural 5 Pending 2 Accident investig   | 28a. Date of In<br>(Month, E                                  | jury 28b. Tii                           | me of 28c. Injur   | v at                                   |   | now injury occurred                          | Journal   |
| Division       | ire ire  | Certification: | 3 Suicide 6 Could n<br>4 Homicide determi  | ned 286. Place of I   | njury - At home, farr<br>etc. (Specify) | m, street, factory, office   |  | 28f. Location (5<br>City or Tox               | Street and Number or<br>vn. State)           | Rural Route Number,                                   |
| 87             | To the Hospital of within 24 hours at To the Funeral D completely filled in  | Medical (      | 29a. Certifier 1 Certifying (Check only one) 1 Medical E   | Physician: To the be-<br>examiner: On the basis<br>and manner | of examination and                      | death occurred at the tir<br>or investigation, in my o                       | ne, date and place<br>pinion, death oc | ce, and due to the curred at the time,        | cause(s) and manner<br>date and place, and d | as stated.<br>ue to the cause(s)                      |
| 3              | To th<br>within  | Ň              | 29b. Signature and title of certifier  | Da  | MD                                      | 29c. Licens  | e number<br>87 4 7                     |   | 29d. Date signed (Md                         | nth, Day, Year)                                       |
|                |  |                | 30. Name and address of person of Randal Riese   |   |   | Type, Print) Incrte( Dr.   | Colum                                  | Dia M   |  | 14  |
|                | Sta<br>Regist  |                | 31. Date filed (Month, Day, Year)  JUL 2 0 26  |   | strar's Signature                       | new  |  |   |  |   |

DHMH 17 Rev 1/2001

ORIGINAL

|             |  |                | riouse  |  |             |                               |                           |                            |                              |                          | ontol Uv                              |                                 | Legibie                    | •              |                                    |      |
|-------------|--|----------------|---|--|-------------|-------------------------------|---------------------------|----------------------------|------------------------------|--------------------------|---------------------------------------|---------------------------------|----------------------------|----------------|------------------------------------|------|
|             |  |                | 1 - For State Registrar   | State of M   | arylar      | •                             |                           |                            | neaim a<br>Death             | tria ivi                 | енан пу                               |                                 | 200                        | C              | 0000                               |      |
|             |  | ы              | Registrar  1. Decedent's Name (First, Middle, Las   | =(1)   |             |                               | Tunca                     | le or i                    | Dealli                       |                          | 2. Date of De                         | Reg. No.                        | _00                        | U              | 3. Time of Deat                    | h U  |
|             | Physicia   | an             |   | •  |             | 11.                           | 1.                        | -                          | _                            |                          | Month                                 | Day                             |                            | ar             |                                    |      |
|             | /Medic   |                | Frederick<br>4a. Facility Name (If not institution, give  | V, Tu  | wa          | 1100                          | 4h Cih                    | Town                       | r Location o                 | of Death                 | <b>ユ</b>                              | 18                              | County of D                | eath           | 3:200                              |      |
|             | Examin   | er             |   |  | . +         |                               |                           |                            | svill                        |                          |                                       | 40.                             |                            |                | nore                               |      |
|             | Funeral  |                | Charlestown 5. Social Security Number 6. S  | ex 7. Ac   |             | last birthday                 | ) If Und                  | er 1 Year                  | If Under 2                   |                          | 8. Date of Bi                         | rth                             |                            | Birthpla       | ce (State or Fore                  | aign |
|             | Director   |                | 040-07-0126   | MM 2□F   | 89          | Yrs.                          | Months                    | Days                       | Hours                        | Min.                     | 8. Date of Bir<br>(Month, Da<br>MAR 1 | $3, \stackrel{\text{Year}}{1}9$ |                            | Country        | ecticut                            |      |
|             | D .  |                | Usuel Residence of Decedent   |  |             |                               |                           |                            |                              |                          |                                       |                                 |                            |                |                                    |      |
|             | arylar<br>show   | h-s            | 10a. State 10b. County  |  | 10c. Cit    | y, Town or L                  | ocation                   |                            |                              |                          |                                       |                                 |                            | 100            | I. Inside City Lim<br>1 ☐ Yes 2    |      |
|             | 8a-f   | cto            | Maryland Baltimo  | re   |             |                               |                           | nsvi                       | 11e                          |                          |                                       |                                 |                            |                |                                    | NO   |
|             | with th  | Directo        | 10e. Street and Number  | . D.   | m 11        | ,                             | 10f. Z                    | ip Code                    | 00                           |                          |                                       | _                               | ten of What                | Country        | /?                                 |      |
|             | a 23c  | Funeral        | 709 Maiden Choice   |  |             |                               | W D                       | 212                        |                              | -:-0 (0                  | -7V                                   |                                 | USA                        |                | la dia -                           |      |
|             | tten de  | ü              | 11. Marital Status  1 □ Never Married 2 □ Married   | 12. Was Decedent<br>Armed Forces:  | Ever in U   | .5.                           | If Yes, sp                | ecify Cuba                 | an, Mexican                  | , Puerto F               | cify Yes or No<br>lican, etc.)        | 0-                              | 4. Race - A<br>Black, W    |                |                                    |      |
| 5           | irs af   | by             | 3 XWidowed 4 □ Divorced   | 1 XYes 2 □<br>If Yes, Give<br>Year or Dates:   | 1942-       | -45                           | 1 🗆 Yes                   | 2 X No                     | Specify:                     |                          |                                       |                                 | Specify:                   | Whi            | te                                 |      |
| 9500-61212  | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "naturel", or items 23a or 28a-f show<br>int, the Madical Examiner must be natified | ted            | 15. Decedent's Ed<br>(Specify only highest gra  |  | 1772        | 16a Dece                      | dent's Us                 | ual Occup                  | ation                        |                          |                                       | 16b. Kir                        | nd of Busine               |                |                                    |      |
| 5           | hin 7  | pie            | (Specify only highest gra   | College (1-4or   | 5+)         | 1                             |                           |                            | during most<br>d)            |                          | g                                     |                                 |                            |                |                                    |      |
| N           | er th  | Completed      | 12  |  |             | Mech                          | anica                     | al En                      | ginee                        | r                        |                                       | F                               | aper                       | Mill           | •                                  |      |
| yland       | al Hy<br>doth<br>event   | Be (           | 17. Father's Name (First, Middle, Last)   |  |             |                               |                           |                            |                              |                          | (First, Middle                        |                                 | Surname)                   |                |                                    |      |
|             | Ment<br>Ment<br>arke<br>atlc   | 2              | John ZuWallack  |  |             |                               |                           |                            |                              | ary v                    | Verhey                                | 1en                             |                            |                |                                    |      |
| Za<br>Za    | 2 sh<br>end<br>le m  |                | 19a. Informant's Name/Relationship (7   |  |             |                               | -                         |                            |                              |                          | Route Numb                            |                                 |                            | e, Zip C       | ode)                               |      |
|             | s 1 and<br>f Heelth<br>Item 27<br>other tr   |                | Robert E. ZuWalla   | ick/Son  | 20h C       | 930<br>Place of Disp          |                           |                            | Drive                        |                          | outus,                                |                                 |                            |                |                                    |      |
| 0           | Pages 1 and 2 should<br>ment of Heelth end Men<br>ent: If Item 27 le marke<br>ury or other treumatic   |                | 20a, Method of Disposition<br>1 X Burial 2 ☐ Cremation 3 ☐  |  | Cre         | emetery cre                   | matory or                 | other plac                 | :е)                          |                          |                                       |                                 | cation - City              |                |                                    |      |
| Baltimore,  | nit. Pa<br>ertmer<br>ortent<br>Injury  |                | 4 Donation 5 Other (Specify   |  |             | morial                        | Gard                      | lens                       |                              | 7/21/                    |                                       |                                 |                            |                | e, MD                              |      |
| n<br>n      | permit. Page<br>Depertment of<br>Importent: If<br>any Injury or<br>once.   |                | 21. Signature of Funeral Service Licen  | egn  |             |                               |                           |                            |                              |                          | Nabb Ft                               |                                 |                            | •              |                                    |      |
|             |  | _              |   | gorchik  | the deat    |                               |                           |                            |                              |                          | Catons                                |                                 | e, MD                      |                | pproximate                         |      |
|             |  |                | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only<br>tmmediate Cause (Final                            | one cause on each l  | ne.         |                               |                           |                            | 3,                           |                          | ,                                     |                                 |                            | lr.            | nterval Between<br>Inset and Death |      |
| 1           | Physician<br>/Medical  |                | disease or condition resulting in death)  | a. Due to (or as   | 11+         | 15                            |                           |                            |                              |                          |                                       |                                 |                            |                |                                    |      |
|             | Examiner   |                |   | Due to (of as  | a conseq    | uence or):                    |                           |                            |                              |                          |                                       |                                 |                            |                |                                    |      |
|             |  | Je.            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events | b. Due to (or as   | a conseq    | uence of):                    |                           |                            |                              |                          |                                       |                                 |                            | -              |                                    |      |
| w/          | ansit  | Examiner       | Cause (Diseese or injury that initiated events  | C  |             |                               |                           |                            |                              |                          |                                       |                                 |                            |                |                                    |      |
| 7,007       | ate be executed sysicien and he buriat-transit   | Ex             | resulting in death) Last  | Due to (or as  | a conseq    | uence of):                    |                           |                            |                              |                          |                                       |                                 |                            |                |                                    |      |
| -           | ate be<br>hysici   | ical           | •   | d  |             |                               |                           |                            |                              |                          |                                       |                                 |                            |                |                                    |      |
| 200         | death certifica<br>e attending ph<br>id for use as th  | ician/Med      | IF FEMALE:  |  |             |                               |                           |                            |                              |                          |                                       | 1                               |                            |                |                                    |      |
| X<br>Q<br>Q | ath o  | ian/           | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome<br>1☐Live birth   | 2 Feta      | I death 3                     | Ectopic                   |                            | ,                            |                          |                                       | 2                               | 3d. Date of<br>Month       | delivery<br>Da |                                    |      |
|             | the de<br>y the a<br>iched f   | ysic           | 1 Yes 2 No  | 4□Pregnant a<br>9□ Unknown   | t time of d | eath 5                        | Other (s                  | specify)                   |                              |                          |                                       |                                 |                            |                | ,                                  |      |
| 7.          | - 0 0  | Physi          | Part II. Other significant conditions of  | ontributing to death b   | out not res | ulting in the u               | underlying                | cause give                 | en in Part I.                |                          | 23e. Did 1                            | obacco us                       | se contribute              | to the         | cause of death?                    |      |
| (i)         | S  | d by           |   | ctive Pu   |             |                               | ~                         | eus                        |                              |                          | 1 🗆                                   | Yes 2                           | ]No 3□                     | Probab         | ly 4 Donkno                        | wn   |
| ູ້ວ         | ~ Q 70   | lete           | Atrial fibrille   |  |             | 7                             |                           |                            |                              |                          | 24a. Was                              | 20                              | 24h Ware                   | autone         | y findings availa                  | blo  |
| Hecord      | el o ci  | Completed      | 2 4   |  |             |                               |                           |                            |                              |                          | auto                                  | psy<br>ormed?                   | prior<br>death             | o comp         | letion of cause of                 | of   |
|             |  | e Cc           | Sever Anema 25. Was case referred to medical  | a  |             |                               |                           |                            | 26 Place                     | of Death                 | 1 ☐ Yes<br>(Check only of             |                                 | 1 🗆 ١                      | 'es 2          | □ No                               |      |
| >           | Physicien:<br>this certific<br>ral director,   | 0 B            | examiner?   | Hospital: 1 ☐ Inpatie  | ent 2 🗆     | ER/Outpatie                   | nt 3 🗆 🗅                  | OA Oth                     | 05                           |                          | e 5 ☐ Resi                            |                                 | □Other /S                  | necify)        |                                    |      |
|             |  | n: T           | 27. Manner of Death   | 28a. Date of Inju  | iry         | 28b. Time o                   |                           | 28c. Injun<br>World        | v at                         |                          | Bd. Describe                          |                                 |                            | poony          |                                    |      |
| 0           | Attending<br>r death.<br>ector: After<br>by the fune   | atio           | 1 ☑Natural 5 ☐ Pending<br>2 ☐ Accident investigation  |  | , , , , ,   | ii ijai y                     | м                         |                            | Yes 2□N                      | No.                      |                                       |                                 |                            |                |                                    |      |
| DIVISION    | r Att  | Certification; | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined   | 28e. Place of In<br>building, et   | ury - At he | ome, farm, st                 | reet, facto               | ry, office                 |                              | 2                        | Bf. Location (<br>City or To          | Street and<br>wn, State)        | Number or                  | Rural F        | loute Number,                      |      |
| 2           | rei Di   |                |   |  |             |                               |                           |                            |                              |                          |                                       |                                 |                            |                |                                    |      |
|             | To the Hospital or Attens within 24 hours after death To the Funeral Director: completely filled in by the   | Medicai        | 29a. Certifier 1 ☐ Certifying Ph<br>(Check only 2 ☐ Medical Exam  | ysician: To the best<br>niner: On the basis of   | t examina   | wledge, dea<br>tion and/or in | th occurre<br>ivestigatio | d at the tin<br>n, in my o | ne, date and<br>pinion, deat | d place, ar<br>h occurre | nd due to the<br>d at the time,       | cause(s) date and               | and manner<br>place, and o | as state       | ed.<br>e cause(s)                  |      |
|             | ithin (ithin on the omple  | Mec            | 29b. Signature and title of certifier   | and manner st  |             |                               | 25                        | c. License                 | e number                     |                          |                                       | 29d. Date                       | signed (Me                 | onth. Da       | v. Year)                           |      |
|             | ⊢≯⊢ŏ   |                | 10.   | P.   | 40.0        | 10                            |                           | 4100                       | 2.1                          |                          |                                       | 71,                             | ela.                       |                |                                    |      |
|             | 111  |                | 30. Name and address of person who  | completed cause of   | eath (Iten  | 23a) (Tyna                    | Print)                    | 773                        | 1 1                          |                          |                                       | 7 [ ]                           | 0/06                       |                |                                    |      |
|             | 45,  |                | Denden Bowlin,  | completed cause of cause of cau | Ma          | iden                          | . Ch                      | محانع                      | 60                           | re                       | Cuton                                 | svill                           | e, 1                       | LN             | 21228                              | ,    |
|             | Sta  |                | 31. Date filed (Month, Day, Year)   | 32 Registr   | ar's Signa  | ture 1                        | 2000                      |                            | W-100                        |                          |                                       |                                 | -                          | -0_            |                                    |      |
|             | Registr  | ar             | JUL 2 1 201   | UD COM   | ~ ~         | T MY                          |                           |                            |                              |                          |                                       |                                 |                            |                |                                    |      |

Physician /Medical **Examiner** 

Funeral Director

To Be Completed by Funeral Director

Physician /Medical **Examiner** 

| Please Type or Print in Black Indelible I   | • • • • • • • • • • • • • • • • • • •                                  |   |
|---|--|---|
| For Amend Item 242 therefore 1,0857,0857,087/212/07   | 術情報 and Mental Hygiene   | 2006 22957  |
| 1 - State Registrar Certificate  1. Decedent's Name (First, Middle, Last)   | OT DEATH Reg. No.  | 3. Time of Death  |
| Harold L. Adams   | July 10  | 2000 11:02 A M  |
| 4a. Facility Name (If not institution, give street and number)  4b. City, Tou   | wn, or Location of Death 4c. C   | County of Death   |
| 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Months D   |  | 9. Birthplace (State or Foreign Coupty)                                     |
| 317-14-2085   15 M 20 F   81 Yrs.   | ays Hours Min. 10/29/192   | 24 Indiana  |
| Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location   |  | 10d. Inside City Limits   |
| MD Harford Aberdee  | n  | ¥∰Yes 2 No  |
| 10e. Street and Number 10f. Zip Co. 357 South Drive 21  |  | ten of What Country?  |
| 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Deceden   | of Hispanic Origin? (Specify Yes or No-                                | 4. Race - American Indian.  |
| 1 Never Married 2X Married  1 Never Married 2X Married  3 Widowed 4 Divorced  Armed Forces?  XXYes 2 No If Yes, Give Year or Dates: 1944-50   | Cuban, Mexican, Puerto Rican, etc.)  No Specify:                       | Black, White, etc.  Specify: White  |
| 1711 34   | ecupation 16b. Kin   | nd of Business/Industry   |
| Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use r   | lone during most of working<br>etired)                                 | vil Service   |
| 12 0 Test Dir   | 18. Mother's Name (First, Middle, Maiden S                             |   |
| Roy L. Adams  | Georgia Bennet   |   |
|   | treet and Number or Rural Route Number, City or                        |   |
|   | Dr., Aberdeen, Man   |   |
| 20a. Method of Disposition  1 Burial 2 Commentation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name commetery, crematory or othe R.A. Ferris&C  | Date 20c. Loc<br>20c. Loc<br>20c. Inc. 7/11/2006 W. C                  | cation - City or Town, State  Chester. PA                                   |
| 21. Signature of Funeral Service Licensee 22. Name and A Tarrin   | ddress of Facility G-Cargo Funeral Hon                                 | me, P.A.  |
|   | Parke Street, Aber   |   |
| 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) | The arction  | Approximate Interval Between Onset and Death                                |
| Due to (or as a consequence of):    Due to (or as a consequence of):  | Disease  | Unknown   |
| d   |  |   |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | nancy  | 3d. Date of delivery<br>Month Day Year                                      |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause Alzheimer's Disease, Dement   | e given in Part I. 23e. Did tobacco us                                 | se contribute to the cause of death?  |
| Hypertension  | 24a. Was an autopsy performed?   | 24b. Were autopsy findings available prior to completion of cause of death? |
|   | 1  Yes 2 No  | 1 Yes 2 No  |
| 25. Was case referred to medical examiner?  Hospital:   | 26. Place of Death (Check only one) Other:                             | 50 n's  |
| 27. Manner of Death 1   | 4 Nursing Home 5 Residence 6 Injury at Work?  28d. Describe how injury | Suther (Specify)  |
| 2 Accident investigation M  | 1 Yes 2 No   |   |
| 4 Homicide  determined  28e. Place of Injury - At home, farm, street, factory, or building, etc. (Specify)  | fice 28t. Location (Street and City or Town, State)                    | Number or Rural Route Number,   |
| 29a. Certifier (Check only one)  **Test Certifying Physician: To the best of my knowledge, death occurred at to the basis of examination and/or investigation, in and manner stated.  |  |   |
| 29b. Signature and title of certifier South MD 15   | cense number 29d. Date   | signed (Month, Day, Year)   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |  | 37121000  |
| Melecia Santos M.D. Vamryland theo  31. Date filed (Marth, Day, Year)  2. 1. 2006  Registrar's Signature  | 1th Care System, Pen   | ryPoint, moalqua  |
| Lander M. Williams  |  |   |

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|        |  |               | 1 - For State Registrar   | tate of Maryland   | -                             | rtment of Hotilicate of L  |   |                                    | jiene                      | 006                                     | ) )<br>hm 6m                          | 953                   |
|--------|--|---------------|---|--|-------------------------------|--|---|------------------------------------|----------------------------|---|---------------------------------------|-----------------------|
| 1      | Physicia   | 11.7          | 1. Decedent's Name (First, Middle, Last)  |  |                               |  |   | 2. Date of Dea<br>Month            | Davi                       | Year                                    | 3. Time o                             |                       |
|        | /Medic   |               | MARY CECELIA SIMMS  |  |                               |  |   | July 4                             |                            |   | 9:31                                  | Рм                    |
|        | Examin   | er            | 4a. Facility Name (If not institution, give stre  |  |                               | 4b. City, Town, or   |   |                                    |                            | ounty of Death                          |                                       |                       |
| 90     | Funeral  | 9.1           | Civista Medical Cen  5. Social Security Number 6. Sex   | 7. Age (In yrs. las  | st birthday)                  | LaPlata<br>If Under 1 Year                                       | If Under 24 Hrs.                          | 8. Date of Birth<br>(Month, Day    | 1                          | arles<br>9. Birth                       | place (State                          | or Foreign            |
|        | Director   | 0             |   | <sup>2</sup> X̄ <sup>F</sup> 87  | Yrs.                          | Months Days  | Hours Min.                                | SEPTEMBE                           | 22,19                      | 918 MAT                                 | RYLAND                                |                       |
|        | and<br>ow  |               | Usual Residence of Decedent  10a. State 10b. County   | 10c. City,   | Town or Loc                   | cation   |   |                                    |                            |   | 10d. Inside C                         | ity Limits            |
|        | Mary<br>-f sho   | tor           | MARYLAND CHARLES  | WELC   | OME                           |  |   |                                    |                            |   | 1 XYes                                | 2 □ No                |
|        | or 28a   | Directo       | 10e. Street and Number  |  |                               | 10f. Zip Code  |   |                                    | l 0g. Citizer              | n of What Cou                           | intry?                                |                       |
|        | 23a  | rail          | 8025 ANNAPOLIS WOODS  |  |                               | 206  |   |                                    |                            | ED STAT                                 |                                       |                       |
|        | n 72 hours aller death with the Maryland<br>"natural", or Items 23a or 28a-f show<br>valce! Exeminat be notified all   | Funeral       | 11. Marital Status 12.  | Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 🛣 No  | 13. V                         | Vas Decedent of His<br>Yes, specify Cubar                        | spanic Origin? (Sp<br>n, Mexican, Puerto  | ecify Yes or No-<br>Rican, etc.)   | 14.                        | Race - Ameri<br>Black, White            |                                       |                       |
|        | ours at  | þ             | 3 Widowed 4 □ Divorced  | If Yes, Give<br>Year or Dates:   | 1                             | □Yes 2□ <b>X</b> No  | Specify:                                  |                                    | Sp                         | pecify: BLA                             | CK                                    |                       |
| ה<br>ה | 72 ho  | Completed     | 15. Decedent's Educat<br>(Specify only highest grade of   | on<br>ompleted)  | 16a. Deced<br>(Give           | ent's Usual Occupa<br>kind of work done d<br>OO NOT use retired) | tion<br>uring most of work                | ing                                | 16b. Kind                  | of Business/Ir                          | ndustry                               |                       |
| 7      | within<br>ene.<br>then "   | mp            | Elementary/Secondary (0-12)  8TH GRADE  | College (1-4or 5+)   |                               | SEWIFE   |   |                                    | номі                       | E MAKER                                 | ,                                     |                       |
| שמ     | filed<br>other<br>ent, ii  | a             | 17. Father's Name (First, Middle, Last)   |  | 1100                          |  | 18. Mother's Nam                          | e (First, Middle,                  |                            |   |                                       | -                     |
|        | uld be<br>Mental<br>rked<br>tic ev   | To B          | HILLARY SIMMS   |  |                               |  | MARY HEL                                  | ENA EDEI                           | EN S                       | EMMS                                    |                                       |                       |
| Mar    | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other then eny injury or other traumatic event, IT a Magnee. | 2             | 19a. Informant's Name/Relationship (Type,   |  |                               | g Address <i>(Str</i> eet a<br><b>ANNAPOLIS</b>                  |   |                                    |                            |   |                                       | 1602                  |
| ر<br>د | 1 and<br>Health<br>em 27<br>ther t   | 0             | MARY HELENA ADAMS /   |  |                               | Sition (Name of  |   | Date                               |                            | tion - City or T                        |                                       | 7093                  |
|        | ages<br>ant of<br>tt; If It<br>y or o  |               | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem<br>4 ☐ Donation 5 ☐ Other (Specify)  | oval from State  | netery, crem                  | natory`or other place<br>ES CEMETE                               |   | 10,2006                            |                            |   |                                       | ND OIL                |
| Daitim | mit. P<br>partme<br>portan<br>/ injur  | - 8           | 21 2 vatura of Funeral Service Licens   | - arl  |                               | HORNTON F  |   | _                                  |                            | 101(1)                                  |                                       | ,2                    |
| Ď      |  |               | LYDIA C. THORNTON   | JOHNSON MOO  | 583 3                         | 439 LIVIN  | GSTON RO                                  | AD, INDI                           | ÀN HI                      | EAD, MA                                 | RYLANI                                | 2064                  |
| ,00    | ate be executed  Medical Examiner  Me purial-Iransit   | icai Examiner | 23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of the shock of heart failure. List only one of the shock of the | Due to (or as a conseque   | ince of):                     | hear   | it Fa                                     | ilure                              | ,                          |   | Approxima<br>Interval Be<br>Onset and | tween<br>Death        |
| j.     | the death certific<br>y the attending pl<br>iched for use as t   | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown | leath 3                       | Ectopic pregnancy<br>Other (specify)                             |   |                                    | 230                        | d. Date of delive                       | ,                                     | Year                  |
| S,     | law requires that the de<br>as been signed by the a<br>2 should be detached  | by Pł         | Part II. Other significant conditions contril   | outing to death but not result   | ing in the ur                 | iderlying cause give   | on in Part I.                             |                                    |                            | contribute to t                         |                                       |                       |
| cora   | requir<br>een si<br>ould   |               |   |  |                               |  |   | 1.64                               | es 2 N                     | No 3 Pro                                | bably 4 🗌                             | Unknown               |
| ပ္     | E 25   | Completed     |   |  |                               |  |   | 24a. Was a<br>autop                | sy                         | 24b. Were auto<br>prior to co<br>death? | opsy findings<br>impletion of a       | available<br>cause of |
|        | Th<br>ate<br>page  | e Co          | 25. Was case referred to medical  |  |                               |  | D0 D1 ( D                                 | 1 Yes                              | 2 <b>SN</b> 0              | 1 🗆 Yes                                 | 2 No                                  |                       |
| VITA   | Physician:<br>this certific<br>ral director,   | 0 8           | examiner?   | pital: 1 ☐ Inpatient 2 🗷 €I  | R/Outpatien                   | t 3 DOA Othe   | 26. Place of Deat                         |                                    |                            | Other (Speci                            | fv)                                   |                       |
|        |  | on: T         | 27. Manner of Death 1 💆 Natural 5 □ Pending   |  | 8b. Time of                   | 28c. Injury<br>Work  | at ?                                      | 28d. Describe h                    |                            |   | <i>57</i>                             |                       |
| S<br>S | Attending<br>ir death.<br>ector; After<br>by the fune  | cati          | 2 Accident investigation  |  |                               |  | res 2 □ No                                | 201.1                              |                            |   |                                       |                       |
| 5      | p # 구 드  | Certificati   | 4 Homicide determined   | 28e. Place of Injury - At hom<br>building, etc. (Specify)                                      | ne, tarm, stre                | eet, factory, office   |   | 28f. Location (S<br>City or Tow    | treet and N<br>n, State)   | lumber or Rur                           | al Route Nun                          | n <i>ber</i> ,        |
|        | Hospita<br>24 hours<br>Funeral<br>tely filler  | edical C      | 29a. Certifier 1년 Certifying Physic (Check only one)  | ian: To the best of my knowl<br>: On the basis of examinatio<br>and manner stated.             | ledge, death<br>on and/or inv | occurred at the tim<br>restigation, in my op                     | e, date and place,<br>sinion, death occur | and due to the cred at the time, c | ause(s) an<br>late and pla | d manner as s                           | stated.<br>to the cause(s             | s)                    |
|        | To the within 2 To the comple  | Me            | 29b. Signature and title of certifier   | 10 M7  | `                             | 29c. License   |   | à                                  | 9d. Date s                 | igned (Month                            | . /                                   |                       |
|        |  |               | 1 Mah Ma  | Mm (1)   |                               | D-522  | 289                                       |                                    | 7                          | -15/                                    | 06                                    |                       |
| 5      | b !  |               | 30. Name and address of person who comp   |  |                               |  | ) / T7_7 1                                | C MD (                             | 20600                      |   |                                       |                       |
| 1      | Sta  | ate           | Nalin Mathur, MD, 1 31. Date filed (Month, Day, Year)   | 32. F gistrar's Signatu  | S Dr.                         | , ste. 40  | , waldo                                   | ri, MD 2                           | 20603                      |   |                                       |                       |
|        | Registi  |               | JUL 0 7 20  | 32. Projistrar's Signatu   | 0 A                           | asser)   |   |                                    |                            |   |                                       |                       |

|  |                | 1 - For<br>State<br>Registrar  |  | Maryland   |                           | artment of H  |   |   | Reg. No.                        | 006 22   | 95                   |
|--|----------------|--|--|--|---------------------------|---|---|---|---------------------------------|--|----------------------|
| Physic<br>/Medi  |                | 1. Decedent's Name (First, Middle, La<br>Cesar F Adamo   | •  |  |                           |   |   | 2. Date of De July                      | eath<br>Day<br>4                | 2 0 0 7:00   |                      |
| Exami  |                | 4a. Facility Name (If not institution, giv<br>Frederick Mem  |  |  | 1                         | 4b. City, Town, or<br>Frede                                       |   | ath                                     |                                 | nty of Death<br>ederick                                      |                      |
| Funeral<br>Director  |                |  | ex<br>M 2,⊕ F  | 7. Age ( <i>In yrs. la</i> s<br><b>82</b>                        | t birthday)<br>Yrs.       | If Under 1 Year<br>Months Days                                    | If Under 24 H<br>Hours Mi                     | n. (Month. D.                           | th<br>ay, Year)<br>16, 192      | 9. Birthplace (State<br>Country)<br>4 Phillippi              | _                    |
| aryland<br>how   |                | Usual Residence of Decedent  10a. State  10b. County   |  | 10c. City, 1   |                           |   |   |   |                                 | 10d. Inside (  |                      |
| the Market Case of Cas | Directo        | alifornia San Die  | 30   | Natio  | naı (                     | 10f. Zip Code   |   |   | 10g Citizen                     | 1 ★ Yes  | s 2 🗌 No             |
| ath with   | raiD           | 650 East 14th  |  |  |                           | 91950   |   |   | U.S.                            |  |                      |
| be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or Iteme 23a or 28a-f show event, the Medical Exerting must be notified at  | by Funerai     | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Deced<br>Armed Ford<br>1 <b>25</b> Yes<br>If Yes, Give<br>Year or Da | 2 🗆 No   |                           | Vas Decedent of Hi<br>fYes, specify Cuba<br>I ☐ Yes 2 ANo         | spanic Origin?<br>n, Mexican, Pue<br>Specify: | Specify Yes or No<br>into Rican, etc.)  |                                 | lace - American Indian,<br>Black, White, etc.<br>city: Asian |                      |
| rithin 72 ho<br>ne.<br>han "natur<br>a Madical I   | Completed      | 15. Decedent's E<br>(Specify only highest gra<br>Elementary/Secondary (0-12)   | ducation<br>de completed)<br>Cottege (1-                                     | 4or 5+)  | life. L                   | lent's Usual Occupa<br>kind of work done of<br>OO NOT use retired | ation<br>furing most of w                     | orking                                  |                                 | Business/Industry  |                      |
| should be filed with and Mental Hygiene marked other that matic event, the   | Be Co          | 12<br>17. Father's Name (First, Middle, Last)  |  |  | store                     | keeper  | 18. Mother's Na                               | ame (First, Middle                      |                                 | Government   |                      |
|  | ToB            | Bonifacio Adamos   |  |  |                           |   | Lore  | nza Ferna                               | ndez                            |  |                      |
| 12.9<br>Tis  |                | 19a. Informant's Name/Relationship ( Ruth Castillo – (   |  |  |                           | g Address (Street a   |   |   |                                 | m, State, Zip Code) aryland 2                                | 1754                 |
| of He  |                | 20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specification)   |  | tate cem   | etery, cren               | sition (Name of natory or other place                             | 1077.   | Date<br>10/2006                         |                                 | n - City or Town, State                                      | •                    |
| permit. Pag<br>Department<br>Important: I<br>any injury o  |                | 21. Sign or of Funeral Service   | 7  | Gien   | - 22                      | Memoria<br>Name and Addres<br>21 Opossi                           | s of Facility                                 | Stauffer<br>Pike, Fre                   | Funera                          | a, Californ<br>l Home<br>, Maryland                          | 1a<br>2170           |
| Physician<br>/Medical<br>Examiner  | er             | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,  | a  | TLACUA<br>r as a consequen                                       | Ce of):                   |   | g, such as cardie                             |   | rest,                           | Approxima<br>Intervat Bei<br>Onset and                       | tween                |
| ficate be executed<br>g physicien and<br>ts the burial-transit   | edicai Examine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | c  | r as a consequen   |                           |   |   |   |                                 |  |                      |
| requires that the death certifics<br>een signed by the attending ph<br>hould be detached for use as th   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 1□Live birt  | ome of pregnancy<br>th 2 □ Fetal de<br>nt at time of death<br>vn | ath 3□                    | Ectopic pregnancy<br>Other (specify)                              |   |   |                                 | Pate of delivery<br>Month Day                                | Year                 |
| w requires that<br>been signed b<br>should be deta   | þ              | Part II. Other significant conditions of   | ontributing to dea   | ith but not resultin   | g in the un               | derlying cause give   | n in Part I.                                  |   | obacco use co<br>'es 2 \sum No  | ntribute to the cause of c                                   | death?<br>Unknown    |
| The law<br>ete has b<br>page 2 st  | Completed      | THE STATE OF THE S |  |  |                           |   |   |   |                                 | Were autopsy findings prior to completion of c death?        | available<br>ause of |
| Physician:<br>r this certific<br>ral director,   | o Be           | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No  | Hospital:  | Sationt 2   ED/  | Outpatient                | Otho  |   | ath Check only o                        |                                 |  |                      |
| and and and and and and and and and and  | ation: T       | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  | 28a. Date of<br>(Month,  |  | o. Time of<br>Injury      | 28c. Injury<br>Work   | 4 🗆 Nursing                                   | dome 5 ☐ Resident 28d. Describe h       |                                 |  |                      |
| ital or Att<br>irs after d<br>ral Direct<br>led in by t  | Certific       | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined  | 288. Place 0   | f Injury - At home,<br>g, etc. (Specify)                         | , farm, stre              | et, factory, office   |   | 28f. Location (S<br>City or Tow         | Street and Num<br>n, State)     | nber or Rural Route Num                                      | ber,                 |
| To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer  | fedical        | ,  | rsician: To the b<br>iner. On the bas<br>and manne                           | is of examination  | dge, death<br>and/or invi | estigation, in my opi   | nion, death occ                               | e, and due to the curred at the time, o | ause(s) and n<br>late and place | nanner as stated.<br>, and due to the cause(s                | ;)                   |
| 5 1 1 P  | ×              | 29b. Signature and title of certifier  |  |  |                           |   | 7796  |   | -                               | ed (Month, Day, Year)  | 6                    |
| Him  |                | 30. Name address of person who catit Verma, M.D  |  | 400  | W. 7                      | rint) h Street  | , Frede                                       | rick, Maı                               | yland                           | 21702  |                      |
| Sta  | te             | 31. Date filed (Month, Day, Year)  | 006 32.  | istrar's Signatu   | 1                         |   |   |   |                                 |  |                      |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** a<sub>м</sub> Belle Allen July 4, 2006 1:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 4753 Cardinal Drive Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/11/1916 9. Birthplace (State or Foreign Country) West Virginia **Funeral** 1 □ M 2 1 F Days Hours Director 271-12-2468 89 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Exercine must be notified at Maryland Directo Wicomico 1 Yes 2 No Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 4753 Cardinal Drive 21804 USA Funeral or Items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2X No δ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Specify white nature!', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Media Specialist Education 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If Item 27 is marked or any injury or other traumatic evenues. Pages 1 and 2 should be Hugh Miller Allen Sr. Mary Ann McCulley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyliss Taylor/caregiver 4753 Cardinal Dr., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sprinchill Memory Gardens 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/7/06 Hebron, MD 21. Signature of Funeral Service Licensee HOLLOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBRAL MONTA /Medical Due to (or as a consequence of): Examiner Atrein Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician a s the burial-t Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 5 Other (specify) ed by the a detached f 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ Be Completed 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy certificate ha 1 ☐ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Tes ZNo Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D36576 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUNIES WD DRIVE 220 ひまたいかけるかり 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0

**ORIGINAL** 

|            |   |                  | For<br>State<br>Registrar                                       |                                    | Stat                                  | te of M                                    | aryland                      | d / Depa<br><i>Cel</i>  |                      | nt of H<br><i>te of L</i>   |                        |                          | /lental                           | , ,  | ene                          | 0.0                      | 220                         | 161        |
|------------|---|------------------|---|------------------------------------|---------------------------------------|--|------------------------------|-------------------------|----------------------|-----------------------------|------------------------|--------------------------|-----------------------------------|--|------------------------------|--------------------------|-----------------------------|------------|
|            |   |                  | 1. Decedent's Name  | e (First, Middl                    | e, Last)                              |  |                              |                         |                      |                             |                        |                          | 2. Date of                        | of Death   | 6.2                          |                          | 3. Time of                  | f Death    |
|            | Physici<br>/Medi  |                  | CHRISTI   | NE BEAT                            | TRICE B                               | RENT                                       |                              |                         |                      |                             |                        |                          | JULY                              |  | 2006                         | Year                     | 6:45                        | A M        |
| }          | Examir  |                  | 4a. Facility Name (/  | f not institution                  | n, give street ar                     | nd number)                                 |                              |                         | 4b. City             | , Town, or                  | Location               | of Death                 | -                                 | •  | 4c. County                   | of Death                 |                             |            |
|            |   |                  | BRADFOR   |                                    | NURSIN                                | G HOM                                      | E                            |                         |                      | NTON                        |                        |                          |                                   |  | PRINC                        | E GEO                    | RGES                        |            |
|            | Funeral<br>Director   |                  | 5. Social Security N 577–38–44                                  |                                    | 6. Sex<br>1 ☐ M 2 ☐                   |  | 9e (In yrs. ia<br>77         | ast birthday)<br>Yrs.   | If Und<br>Months     | Days                        | If Unde<br>Hours       | Min.                     | 8. Date of                        | f Birth  | (ear)                        |                          | place (State o              | or Foreign |
|            | _   |                  | Usual Residence of  |                                    |                                       |  |                              |                         |                      |                             |                        |                          | JULY                              | 23,  | 1928                         | MARY                     | LAND                        |            |
|            | ehow  |                  | 10a. State  | 10b. County                        |                                       |  | 10c. City                    | , Town or Lo            | cation               |                             |                        |                          |                                   |  |                              | 1                        | 0d. Inside Ci               | ity Limits |
|            | death with the Maryland<br>ms 23s or 28s-f ehow<br>r.must be notified at                                    | ctor             | MD  | PRINC                              | E GEORG                               | ES   | FOR'                         | T WASH                  | INGI                 | ON                          |                        |                          |                                   |  |                              |                          | <b>™</b> Yes                | 2 ☐ No     |
|            | ith th  | Dire             | 10e. Street and Nur   |                                    |                                       |  |                              |                         | 10f. Z               | p Code                      |                        |                          |                                   | 100  | g. Citizen of \              | What Cour                | ntry?                       |            |
|            | ath w   | rai              | 1323 OLD  | PISCA'                             |                                       |  |                              |                         |                      | 744                         |                        |                          |                                   |  | NITED                        |                          |                             |            |
|            | it en de  | Funeral Director | 11. Marital Status 1 ☐ Never Marri                              | ad 20 Mar                          | Arm                                   | Decedent<br>ed Forces?                     |                              |                         | Nas Dec<br>f Yes, sp | edent of His<br>ecify Cubai | spanic O<br>n, Mexica  | rigin? (Sp<br>an, Puerto | ecify Yes of Rican, etc           | or No-<br>.)   |                              | e - Americ<br>ck, White, |                             |            |
| 5-0036     | 72 hours after<br>naturel', or ite  | by               | 3 X Widowed   | _                                  | If Ye                                 | Yes 2. <b>X</b> ∏<br>es, Give<br>rorDates: | NO                           |                         | 1 🗆 Yes              | 2 <b>X</b> No               | Specify                | <i>/</i> :               |                                   |  | Specifi                      | BLA                      | CK                          |            |
| 9-0        | 2 hou   | ted              | (0  | 15. Deceden                        | it's Education                        | !  |                              | 16a. Dece               | ent's Us             | al Occupa                   | ition                  |                          |                                   | 16   | Bb. Kind of B                |                          |                             |            |
| 2          | within 7<br>ene.<br>than "r   | Completed        | Flementary/Seco   |                                    | st grade compl                        | ege (1-4or 5                               | 5+)                          | life.                   | DO NOT               | ork done d<br>use retired)  | )                      | ist of work              | ang                               |  |                              |                          |                             |            |
| 7          | filed w<br>Hygien<br>ther th  | ပ်               | 9TH   |                                    |                                       |  |                              | NURSE                   | S AS                 | SISTA                       |                        |                          |                                   | FEDERAL GOVERNMENT                                   |                              |                          |                             |            |
| Maryland   | B la o ≥  | Be               | 17. Father's Name   |                                    | ,                                     |  |                              |                         |                      |                             |                        |                          | e (First, Middle, Maiden Surname) |  |                              |                          |                             |            |
| Ž          | hould<br>d Men<br>marka<br>matic  | ဥ                | 19a. Informant's Na   |                                    |                                       | e)   |                              | 10h Mailir              | a Addros             | -                           |                        |                          |                                   | RICK COLBERT  (umber, City or Town, State, Zip Code) |                              |                          |                             |            |
| Ma         | ith an Ith an 27 is trau  |                  | GWENDOLY  |                                    |                                       | •  |                              |                         |                      |                             |                        |                          |                                   |  | SHING                        |                          |                             | 744        |
| ē,         | t Healthem  |                  | 20a. Method of Disp   |                                    |                                       |  |                              | ace of Dispo            | sition (Na           | me of                       | - 1                    |                          | Date                              | -  | c. Location                  |                          |                             |            |
| Ë          | Page<br>tent o<br>nt: If<br>ry or   |                  | 1 □ Burial 2  <br>4 □ Donation                                  |                                    | 3 □Removal<br>Specify)                | from State                                 | 1                            | metery, crer<br>VETERAN |                      |                             | 1                      | лиу                      | 14 200                            | % C  | HELTEN                       | шлм                      | MADVI                       | AND        |
| Baltimore, | permit. Depertm Imports any Inju  |                  | 21. Signature of Fu   | neral Service                      | Licensee /                            | - Ook                                      | 1                            |                         |                      |                             |                        |                          | HOME,                             |  |                              | ши                       | TIMELL                      | AND        |
| <u>m</u>   | 89 = 29   |                  | LYDIA   | C. THO                             | ORNTON .                              | JOHNSO                                     | ON                           | 1 2                     | 3439                 | LIVI                        | NGST                   | ON R                     | OAD,                              | INDI   | AN HEA                       | D, M                     | D 2064                      | 0          |
|            |   |                  | 23a. Part1. Enter the shock, or hea                             | ne disease, or<br>rt failure. List | complications only one cause          | that caused<br>agn each li                 | the death                    | . Do not ent            | er the mo            | de of dying                 | , such a               | s cardiac                | or respirato                      | ry arrest  | t,                           | 11125                    | Approximate<br>Interval Bet | ween       |
| +          | Physician   |                  | tmmediate Cause (<br>disease or condition                       |                                    | a                                     | ALZ  | ZHE                          | IMI                     | ZR                   | S                           | 18                     | 1SF                      | FAS                               | Æ  |                              |                          | Onset and I                 | Death      |
|            | /Medical<br>Examiner  |                  | resulting in death)   |                                    | Di                                    | ue to (or as                               | a consequ                    | ence of):               |                      |                             |                        |                          |                                   |  |                              |                          |                             |            |
|            |   | <u></u>          | Sequentially list con   | nditions,                          | b                                     | ue to (or as                               | a consequ                    | ence of):               |                      |                             |                        |                          |                                   |  |                              |                          |                             |            |
|            | uted<br>Insit   | Examiner         | if any, leading to in<br>cause. Enter Unde<br>Cause (Diseese or | rtying<br>injury                   | <b>く</b> ご                            | 20 10 (01 43                               | a oonsoqu                    | 01100 01).              |                      |                             |                        |                          |                                   |  |                              |                          |                             |            |
| ć          | icate be executed<br>physicien and<br>the burial-transit  | Еха              | that initiated events<br>resulting in death) (                  | ast                                | C                                     | ue to (or as                               | a consequ                    | ence ol):               |                      |                             |                        |                          |                                   |  |                              |                          |                             |            |
| 68760,     | te be<br>ysicie   | dicai            |   |                                    | <b>L</b> d                            | _  |                              |                         |                      |                             |                        |                          |                                   |  |                              |                          |                             |            |
|            |   | 1 W              | IF FEMALE:  |                                    |                                       |  |                              |                         |                      |                             |                        |                          |                                   |  |                              |                          |                             |            |
| Вох        | death certifica<br>attending ph<br>of for use as t  | an/I             | 23b. Was decedent<br>in the past 12                             |                                    |                                       | s, outcome<br>Live birth                   |                              |                         | Ectopic p            | regnancy                    |                        |                          |                                   |  |                              | e of delive              |                             |            |
| 0.         | the at  | Physician/M      | 1 ☐ Yes 2 ☐<br>9 ☐ Unknown                                      |                                    |                                       | Pregnant at<br>Unknown                     | t time ot de                 | ath 5□                  | Other (s             | pecify)                     |                        |                          |                                   | -  | Mo                           | ntn                      | Day Y                       | Year       |
| P.0        | that the de<br>led by the a<br>detached t   |                  | Part II. Other signif   | icant condition                    | ons contributing                      | to death b                                 | ut not resul                 | Iting in the ur         | nderlying            | Carles dive                 | n in Part              | 1                        | 23e I                             | Oid tobac  | cco use cont                 | nhute to th              | e cause of d                | leath?     |
| Records,   | S 20 0  | d by             |   |                                    |                                       | ,  |                              |                         |                      | 3.10                        |                        | ••                       |                                   | Yes  | _                            | 3 ☐ Prob                 |                             | Jnknown    |
| S          | w requir<br>been si<br>should   | Completed        |   |                                    |                                       |  |                              |                         |                      |                             |                        |                          | 242 1                             | Mas an   | 245.1                        | Moro autor               | osy findings a              | available  |
| Re         | The lav   | E C              |   |                                    |                                       |  |                              |                         | -                    |                             | <del></del>            |                          | F                                 | utopsy<br>erforme                                    | d2/ 5                        | prior to con<br>leath?   | npletion of ca              | ause of    |
| Vital      | ysicien: The<br>is certificate hu<br>director, page   | 0                | 25. Was case refer  | red to medica                      |                                       |  |                              |                         |                      |                             | 26 Plac                | e of Deat                | 1 ☐ Y                             |  | No 1                         | ☐ Yes                    | 2∐ No                       |            |
| f V        | Physician:<br>this certifica<br>ral director, j   | To B             | examiner?   | No                                 | Hospital:                             | 1 🗌 Inpatie                                | ent 2 E                      | R/Outpatien             | t 3 D                | Othe                        | c /                    |                          |                                   |  | e 6 □Oth                     | er (Specify              | ·)                          |            |
|            | ding Phy<br>h.<br>After thi<br>funeral c  |                  | 27. Manger of Death   | n<br>5 ☐ Pendin                    | 28a.                                  | Date of Inju<br>(Month, Da)                | ry<br>y Year)                | 28b. Time of<br>Injury  |                      | 28c. Injury<br>Work         |                        |                          |                                   |  | injury occurr                |                          | <u> </u>                    |            |
| Division   | Attending<br>ir death.<br>ector: After<br>by the fune   | Certification:   | 2 Accident  | investi                            | gation                                |  |                              |                         | М                    |                             | ′es 2 🗆                | ]No                      |                                   |  |                              |                          |                             |            |
| Ξ̈́        | or Att  | Ē                | 3 Suicide 4 Homicide  | determ                             | ined   289.                           | Place of Injude                            | ury - At hor<br>c. (Specify) | ne, farm, str           | eet, facto           | y, office                   |                        |                          | 28f. Location City or             | on (Stree<br>Town, S                                 | et and Numb<br>State)        | er or Rura               | Route Numi                  | ber,       |
|            | pital<br>ours a<br>erel C   |                  | 29a. Certifier  | 1 Cantierin                        | og Photos                             | Fo the base                                | of multi                     | uladas dirit            |                      |                             |                        |                          |                                   |  |                              |                          |                             |            |
|            | To the Hospital or Attence within 24 hours after death To the Funerel Director: completely filled in by the | Medical          |   | 2   Medica                         | g Physician: 1<br>Examiner: On<br>and | the basis of<br>manner sta                 | f examinati                  | on and/or inv           | estigation           | at the time<br>n, in my op  | e, date a<br>inion, de | nd place,<br>ath occuri  | and due to<br>ed at the ti        | me, date   | se(s) and ma<br>and place, a | nner as stand due to     | ated.<br>the cause(s)       | )          |
|            | To the  | ₩.               | 29b. Signature and  | title of cantie                    |                                       |  |                              |                         | 29                   | c. License                  | number                 |                          |                                   | 29d.   | . Date signed                | (Month, l                | Day, Year)                  |            |
|            |   |                  | <b>)</b> /  | (/                                 | 11-                                   |  |                              |                         |                      | 52                          | 14                     | (                        |                                   | -  | 1 1                          | 101                      |                             |            |
| (          |   |                  | 30. Name and address  | ss of person                       | who completed                         |  |                              | 23a) (Type,             | Print)               |                             | 1_                     |                          | 0 1                               | 7  | , \                          |                          | +                           |            |
| 3          | 82  |                  | UAMOL   | INE                                | CAIN                                  | EN   | ND_                          | 1170                    | 14                   | VINO                        | iSTV                   | 00                       | ILD:                              | 17   | Was                          | ning                     | nation                      | MD         |
|            | Sta<br>Registr  |                  | 31. Date filed (Mont  |                                    | 7 2006                                | 32. gistra                                 | ar's Signati                 | H A                     | and.                 | ,                           | (                      |                          |                                   |  |                              | ı                        |                             |            |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ellen Virginia June 28, 2006 9:40 a Blanchard 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Montgomery Park 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🗓 F 579-50-2977 68 DC Jan. 12,1938 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1608 Street N. E. 20002 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Examiner Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Reedv Blanchard Vivian Ε. Burris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renard E. Blanchard, Sr./Son 7214 Lansdale Street District Heights, Md.20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cem. 7/5/06 Washington, DC 4 □ Donation 5 □ Other (Specify) 21. Signature of Furieral Service Licensels Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Md. 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): DIYA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events a consequence of). resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Ulca 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 20No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Marient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated D45666

or Attending Physician: The law requires that the death certificate be executed been signed by the attending physicien end should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

rei', or items 23e or 28a-f ehow Examiner must be notified at

permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked oth eny lighty or other traumatic event page.

Physician

/Medical

Examiner

Director

Completed by

Be

Examine

Physician/Medical

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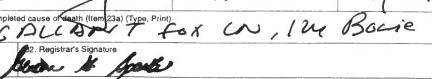
Certification:

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) JUL 0 5 2006



nd address of person who completed cause of seath (Item 23a) (Type, Print)

|                            |  | •                   | For<br>State<br>Registrar  | State of Marylan   |                                  | artment of He<br>rtificate of D                                |   |   | ene<br>g. No.        | 06  | 22963   |
|----------------------------|--|---------------------|--|--|----------------------------------|--|---|---|----------------------|---|---|
|                            | Physici  |                     | Decedent's Name (First, Middle, Last)     DOROTHY  | BLACKISTONE  |                                  |  |   | 2. Date of Death<br>Month<br>JUNE 25                                      | Day 2006             | Year  | 3. Time of Death 4:25 PM                                |
|                            | /Medic<br>Examin   | _                   | 4a. Facility Name (If not institution, give st   | reet and number)   |                                  | 4b. City, Town, or l   |   | JONE 25   | 4c. Count            |   |   |
|                            |  | ,0                  | PRINCE GEORGE'S H  5. Social Security Number 6. Sex  | OSPITAL  7. Age (In yrs.   | last birthdav)                   | CHEVER   | LY If Under 24 Hrs.   | 8. Date of Birth  |                      |   | DRGE'S  |
|                            | , Funeral<br>Director  |                     | 577-01-6371  | M 280 F 90   | Yrs.                             | Months Days  | Hours Min.  | (Month, Day,<br>MARCH 25  |                      | Cour  | SHINGTON, DC  |
|                            | yland  |                     | Usual Residence of Decedent  10a. State 10b. County  | 10c. Cit   | y, Town or Lo                    | ecation  |   |   |                      | 1   | 0d. Inside City Limits                                  |
|                            | 8a-fet   | ector               | MD PRINCE GE   | ORGE'S L   | ANDOVE                           |  |   |   |                      |   | 1 X Yes 2 □ No  |
|                            | 3a or 2  | i Dir               | 10e. Street and Number 1811 PALMER PARK  | ROAD   |                                  | 10f. Zip Code<br>20785   |   |   | og. Citizen of U.S.  |   | itry ?  |
| 9                          | permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow eny injury or other traumatic event, it a Medical Examination trait to notified at 2008. | by Funeral Director | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 2. Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates: |                                  | Was Decedent of His<br>If Yes, specify Cuban<br>1 ☐ Yes 2 ☑ No | panic Origin? (Sp<br>, Mexican, Puerto<br>Specify:                              | ecity Yes or No-<br>Rican, etc.)  |                      | ce - Americ<br>ick, White,                                |   |
| 00-10                      | 72 hour<br>naturel   | ted b               | 15. Decedent's Educi<br>(Specify only highest grade  | ation  | 16a. Dece                        | dent's Usual Occupat   | ion   | una .   | 6b. Kind of E        |   |   |
| 21215-0036                 | within 7<br>ane.<br>then "r  | Completed           | Elementary/Secondary (0-12)  | College (1-4or 5+) 4 yrs   | life.                            | DO NOT use retired) OGRAM ANAI                                 |   | ,,,,,   | GOVERN               | MENT  |   |
|                            | il Hygie<br>other  | Be Co               | 17. Father's Name (First, Middle, Last)  | 7 y13  | 1 10                             |  | 18. Mother's Nam  | e (First, Middle, M   | laiden Suma          |   |   |
| Maryland                   | ould by<br>Menta<br>Marked<br>Marked   | To E                | CHARLES MITCHELL   |  |                                  |  | SARAF   |   |                      |   |   |
| Mar                        | nd 2 sh<br>lith and<br>27 is m<br>r traum  |                     | 19a. Informant's Name/Relationship (Type PATRICIA A. NEWT  | on/DAUGHTER  |                                  | ng Address (Street ar<br>PALMER PA                             |   |   | _                    |   | 20785   |
| Baltimore,                 | Pages 1 au<br>nent of Hea<br>ant: If item<br>ury or othe   |                     | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)   | moval from State   | Place of Dispo<br>emetery, crer  | esition (Name of<br>matory or other place<br>CTION CEME        | ,   | Date 2  | CLINTO               | - City or To  |   |
| Balt                       | permit. Depertrimports eny inje  |                     | 21. Signature of Funeral Service License   | all  |                                  | 2. Name and Address  | J   | B. JENE<br>LANDOVE  |                      |   | HOME 20785  |
| 58760,                     | Physician and Sharian-Iransit sthe purial-Iransit  | dicai Examiner      | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.   | Due to (or as a conseq   | uence of):                       | er the mode of dying   |   | or respiratory arre   | St,                  |   | Approximate Interval Between Onset and Death            |
| P.O. Box 68                | death certiff<br>e ettending<br>ed for use as  | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \) Unknown   | c. If yes, outcome of pregna<br>1 Live birth 2 Feta<br>4 Pregnant at time of c<br>9 Unknown    | ildeath 3□                       | Ectopic pregnancy Other (specify)                              |   |   |                      | ate of delive   | ory<br>Day Year   |
|                            | law requires that the<br>as been signed by th<br>2 should be detache   | þ                   | Part II. Other significant conditions continued the significant conditions continued the significant conditions continued to the significant conditions conditions continued to the significant conditions conditi | nbuting to death but not res   | ulting in the u                  | nderlying cause giver  | n in Part I.  | 23e. Did tob  | ~/                   |   | ne cause of death?                                      |
| Division of Vital Records, | The<br>ate h<br>page   | Completed           | - Acute R  | espuotory  | Fail                             | المراج   |   | 24a. Was ar<br>autops<br>perform<br>1 Yes 2                               | /                    | Were auto<br>prior to con<br>death?<br>1 \( \subseteq Yes | psy findings available<br>appletion of cause of<br>2 No |
| VIII.                      | Physician: Th<br>this certificate<br>ral director, pag   | To Be               | 25. Was case referred to medical examiner?   | spital:  | EB/Outpatier                     | Other  |   | h (Check only one   |                      | har (Snacih   | <i>(</i> )  |
| on of                      | ding Phys<br>J.<br>After this<br>funeral di  |                     | 27. Manner of Death 1 Death 5 ☐ Pending  | 28a. Date of Injury (Month, Day Year)   28b. Time of Injury   M   1   Yes 2   No               |                                  |  |   | dome 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred |                      |   |   |
| Division                   | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral  | Certification:      | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)         |                                  |  | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |   |                      |   |   |
|                            | To the Hospital within 24 hours a To the Funeral Completely filled   | edicai C            | 29a. Certifier (Check only one) Certifying Physical Examination (Check only one)   | cian: To the best of my kno<br>er: On the basis of examina<br>and manner stated.               | owledge, deat<br>ation and/or in | h occurred at the time<br>evestigation, in my opi              | e, date and place,<br>nion, death occur   | and due to the ca   | use(s) and materials | anner as st<br>and due to                                 | ated. the cause(s)                                      |
| )                          | To th<br>To th<br>comp   | Me                  | 29b. Signature and title of certifier  | Lear   | $\overline{}$                    | 29c. License   | 52865   |   | June                 |   | Day, Year)<br>+L ZOOLO                                  |
| 2                          | (6)  |                     | 30. Name and address of person who cor   | preted cause of death (Iter  | n 23a) (Type,                    | Print) A Je DR   | ve /  | 3 Euie  | M                    | D   |   |
| COLA                       | Sta<br>Regist  |                     | 31. Date filed (Month, Day, Year)  JUL 0 5 2006  | prefeted cause of death (Iter  | Share .                          | ts)  | •   |   |                      |   |   |
|                            |  | ŕ                   | 00L 0 0 2000   | 1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-   | 7                                |  |   |   |                      |   |   |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 10:47 AM Mary Elizabeth Biskach 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CAMBRIDGE ORCHESTER DORCHESTER GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🛣 F Director 165-14-0451 88 Oct. 16, 1917 Maryland Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location or than "natural", or Items 23a or 28a-1 show the Medical Extending to ust be ricitlised at Dorchester Hurlock 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6420 Cabin Creek Road 21643 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 6 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be fi Mental H Charles Pospeshill Mary Holeshack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trau once. Louis Biskach 6431 Cabin Creek Road, Hurlock, MD 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Our Lady of Good 7/8/06 4 ☐ Donation 5 ☐ Other (Specify) Secretary, MD Counsel Churchyard ress of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. B, 700 Locust St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis 4 hows **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit the death certificate be executed Due to (or as a consequence of): physician a s the burial-1 Box 68760, Physician/Medical as the attending for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 FR/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending s after death.
Il Director: Aft
id in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 50804 J.M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Cambridge, MD Mallux, MD. 408 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrai

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   | •                             | For<br>State<br>Registrar  | State of Marylar  | nd / Depa  |  | Health and M  | ental Hygi  |   | 22965  |  |
|---|-------------------------------|--|---|--|--|---|---|---|--|--|
| Physicia  | n                             | Mo   |   |  |  |   |   | Date of Death Month Day Year July 4 2006 7:4  |  |  |
| /Medica<br>Examine  | r                             | Ethel E. Ben<br>4a. Facility Name (If not institution, give s<br>Genesis HealthCa  | treet and number)   | ines   |  | or Location of Death  | July  | 4c. County of Death                           |  |  |
| Funeral<br>Director   |                               | 5. Social Security Number 6. Sex 154-28-4912   | 7. Age (In yrs<br>83  | last birthday)<br>Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs. Hours Min.   | 8. Date of Birth<br>(Month, Day,<br>Sept. 1           | 9. Birth<br>9, 1922 New                       | place (State or Foreign<br>intry)<br>Jersey              |  |
| Ba-f show   | ector                         | 10a. State 10b. County  NJ Glouce  |   | ity, Town or Le  | estville   |   |   |   | 10d. Inside City Limits 1 ☐ es 2 ☐ No                    |  |
| 3 with the  | ם ב                           | 10e. Street and Number 708 Almonesson Rd   |   |  | 10f. Zip Code<br>080   | 93  | 10  | ng. Citizen of What Cou<br>USA                | intry ?  |  |
| ges 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumetic event, the Marylan Examinat must be morified at | Completed by Funeral Director |  | 2. Was Decedent Ever in U<br>Armed Forces?<br>1 ☑ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates: WW |  |  | Hispanic Origin? (Spe<br>an, Mexican, Puerto I                                  | cify Yes or No-<br>Rican, etc.)                       | 14. Race - Amer<br>Black, White<br>Specify:   |  |  |
| 21215-0036 d within 72 hours aft gione or then "natural", or the Medical Exam   | mpleted                       | 15. Decedent's Edui<br>(Specify only highest grade<br>Elementary/Secondary (0-12)  | cation<br>completed)<br>College (1-4or 5+)  | 16a. Dece<br>(Give<br>life.                                    | dent's Usual Occup<br>kind of work done<br>DO NOT use retire<br>Homemake | during most of workii<br>d)   | ng 1  | 6b. Kind of Business/li  Own                  | ndustry  |  |
| yland 2  ould be filed v  Mental Hygic arked other etic event, t  | Be                            | 17. Father's Name (First, Middle, Last)  Joseph Hoffman  |   |  | Homemake   | 18. Mother's Name   |   |   | `  |  |
| Maryland d 2 should be file the and Mental Hy ty is marked oth traumetic event  | 2                             | 19a. Informant's Name/Relationship (Type   | oe, Print)  | 19b. Maili   | ng Address (Street   |   |   | n name unkr<br>City or Town, State, Zi        |  |  |
| e, M. 1 and 2 1 ealth 3 9 m 27 is   |                               | David M. Bennett/So  |   | Place of Dispo   | 410 Tour   | Dr., East   |   | 21601<br>20c. Location - City or T            | own. State   |  |
| Baltimore, N permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr ance.  |                               | 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21 Sonature of Funeral Sender License  | Mic   | 1Shore(  |  | Center7/5/<br>cess of Facility<br>comwell Fur<br>St., Cambr                     | 2006  | Cambride.                                     |  |  |
| Pnysician<br>/Medical   |                               | 23a Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)               | cations that caused the deale cause on each line.   | quence of):  | ter the mode of dyl  | ng, such as cardiac o   | r respiratory arre                                    | D 21613<br>st,                                | Approximate<br>Interval Between<br>Onset and Death       |  |
| 76<br>te be<br>ysicia   | icai Examiner                 | Sequentially list conditions. If any, loading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conse<br>Due to (or as a conse  |  | r snsu<br>preculi  | ffeiency<br>e <sub>f</sub> l  |   |   | yeers<br>izems   |  |
| .O. BOX 687 the death certificate by the attending phys ached for use as the  | Completed by Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  | 3c. If yes, outcome of pregr<br>1 Live birth 2 Fet<br>4 Pregnant at time of<br>9 Unknown          | al death 3   | □Ectopic pregnanc □ Other (specify)                                      | у   |   | 23d. Date of deliv                            | rery<br>Day Year   |  |
| ords, P.O. I  | d by Pr                       | Part II. Other significant conditions con  | ven in Part I.  |  | Did tobacco use contribute to the cause of deat                          |   |   |   |  |  |
| Vital Records, sician: The law requires to certificate has been signer rector, page 2 should be   | Complete                      | Repolatell carel   | neona   |  |  |   | 24a. Was ar<br>autopsy<br>perform<br>1 Yes 2          | prior to co                                   | opsy findings available<br>ompletion of cause of<br>2 No |  |
| Vita  | To Be                         | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ★ No  | ospital:  | al: 1   Inpatient 2   EP/Outpatient 3   DOA Other: Mursing Hor |  |   | th (Check only one) ome 5 Residence 6 Other (Specify) |   |  |  |
| Sing ling   | ation: T                      | 27. Manner of Death  Control Natural 5 Pending 2 Accident Investigation  | 28a. Date of Injury<br>(Month, Day Year)  |  |  |   | 28d. Describe how injury occurred                     |   |  |  |
| TS ST ST ST ST ST ST ST ST ST ST ST ST S  | Certification:                | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)            |  |  | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |   |   |  |  |
| Hospi<br>24 hou<br>Funer<br>etely fill  | Medical                       | 29a. Certifier Check only one) Certifying Physical Examination (Check only one)  | sician: To the best of my kr<br>ner: On the basis of examin<br>and manner stated.                 | owledge, dea<br>ation and/or in                                | h occurred at the ti<br>vestigation, in my                               | me, date and place, a opinion, death occurre                                    | and due to the ca<br>ed at the time, da               | use(s) and manner as<br>te and place, and due | stated.<br>to the cause(s)                               |  |
| To the Hos<br>within 24 hr<br>To the Fur<br>completely  | Me                            | 29b. Signature and title of certifier  | Year Men and  |  | 29c. Licen   | se number   | 29  | Pd. Date signed (Month)                       | Day, Year)   |  |
|   |                               | 30. Name and address of person who co  | mpleted cause of death (Ite   | m 23a) (Type   | Print) UTCHMAN   | 's LANE   | EA  | STON MD                                       | 21601  |  |
| Stat<br>Registra  |                               | 31. Date filed (Month, Day, Year)  | 2006 32. Registrar's Sign   | nature   | Smarth !   |   |   | ,       |  |  |

DHMH 17 Rev 1/2001

Ethel Bennett

Catherine Leigh Bangs

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

| Several   Seve   | atherne Leigh  | 1  | orate of that years a part   | cate of Death  | Reg No2 0 1 6 2 2 9 6                            |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|
| A SCALLY MAN CATTOR CORRESPONDED TO COLORS AND COLORS AND CATTOR OF THE |  | 38 U/  |  |  | Month Day Year                                   |  |  |  |  |  |  |  |
| Second Security Number   Second Security Number   Second Security Number   Second Security Number   Second Security Number   Second Security Number   Second Security Number   Second Security Number   Second Secon | neulcai Exami  |  |  | 4b. City, Town, or Location of Deat  | July 5, 2000                                     |  |  |  |  |  |  |  |
| 217-73-3765  |  |  | Baltimore Washington Medical Center  | Glen Burnie  | Anne Arundel                                     |  |  |  |  |  |  |  |
| The street and Number 1 to Cooking Annual Line (Cooking  |  | 217-73-3765 1_M 2\(\overline{X}\)F   | Months Days Hours Mil  | Foreign  |  |  |  |  |  |  |  |
| State   Stat   | ž .  |  | 10a. State 10b County 10c. City, Tow   |  | 10d Inside City Limits 1 Yes 2 X No              |  |  |  |  |  |  |  |
| The first of the state of the s | the Marylan<br>a or 28a-f s  | Directo  |  |  |  |  |  |  |  |  |  |  |
| The Maling Address (Sieve and Number or Rural Roade Number: City or Town State; Zo Cook)  John Bangs/Father  352 Monte Cristo Court, Severin, MD  John Bangs/Father  352 Monte Cristo Court, Severin, MD  John Bangs/Father  352 Monte Cristo Court, Severin, MD  John Bangs/Father  Jo | r death with  or items 23  | Funeral  | 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No   | If Yes, specify Cuban, Mexican, Puert  | o Rican, etc.) White, etc.                       |  |  |  |  |  |  |  |
| The Maling Address (Sieve and Number or Rural Roade Number: City or Town State; Zo Cook)  John Bangs/Father  352 Monte Cristo Court, Severin, MD  John Bangs/Father  352 Monte Cristo Court, Severin, MD  John Bangs/Father  352 Monte Cristo Court, Severin, MD  John Bangs/Father  Jo | hours afte<br>natural",<br>Examiuer  | ⋧  | 15. Decedent's Education (Specify only highest grade completed) 16   | a. Decedent's Usual Occupation (Give kind of   | work done 16b. Kind of Business/Industry         |  |  |  |  |  |  |  |
| The first of the state of the s | 0036<br>within 72<br>iene<br>er than "   | omplet   | N/A  | •  |  |  |  |  |  |  |  |  |
| The state of the s | 715-<br>e filed<br>al Hyg<br>ced oth   |  |  |  | •  |  |  |  |  |  |  |  |
| Physician Medical Table 1   22a Part Linet the disease or complications that caused the death. Do not enter the mode of dying, such as cardade or respiratory arrest, shock, or heart failure. List only one cause or each line.    22a Part Linet the disease or complications that caused the death. Do not enter the mode of dying, such as cardade or respiratory arrest, shock, or heart failure. List only one cause or each line.    22a Part Linet the disease or complications that caused the death. Do not enter the mode of dying, such as cardade or respiratory arrest, shock, or heart failure. List only one cause or each line.    22a Part Linet the disease or complications that caused the death. Do not enter the mode of dying, such as cardade or respiratory arrest, shock, or heart failure. List only one cause or each line.    22a Part Linet the disease or complications that caused the death. Do not enter the mode of dying, such as cardade or respiratory arrest, shock, or heart failure. List only one cause or each line.    22a Part Linet the disease or complications that caused the death. Do not enter the mode of dying, such as cardade or respiratory arrest, shock, or heart failure. List only one cause or each line.    22a Part Linet the disease or complications that caused the death. Do not enter the mode of dying, such as cardade or respiratory arrest, shock, or heart failure. It is not provided to the cause of death. Do not enter the mode of dying, such as cardade or respiratory arrest, shock, or heart failure. It is not provided and the line death. Do not enter the mode of dying, such as cardade or respiratory arrest, shock, or heart failure. It is not failure. It is not failure. It is not failure. It is not failure. It is not failure. It is not failure. It is not failure. It is not failure. It is not failure. It is not failure. It is not failure. It is not failure. It is not failure. It is not failure. It is not failure. It is not failure. It is not fail the failure. It is not failure. It is not failure. It is not fa | 212<br>buld be<br>I Ment<br>mark<br>ic ever  |  |  |  |  |  |  |  |  |  |  |  |
| Physician Microsoft Part   22a Part   Enter the disease of complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart   Approximate interval Survival Part   Approximate  | MD<br>d 2 shc<br>lith and<br>n 27 is   |  |  |  |  |  |  |  |  |  |  |  |
| Physician Microsoft Part   22a Part   Enter the disease of complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart   Approximate interval Survival Part   Approximate  | more, Pages I an nent of Hea ant: If iter  |  | 1 XBurial 2 Cremation 3 Removal from State crem  | phany Church Cem.  | ly 17,<br>2006 Odenton, MD                       |  |  |  |  |  |  |  |
| Physician (Modical Xamilion  Tamilion  Balti<br>permit<br>Departn<br>Imports<br>injury c  |  | 21. Signature of Funeral Service Licensee  | 22. Name and Address of Facility<br>Barranco & Sons,<br>495 Ritchie Hwy,   | P.A. Severna Park F.H.<br>Severna Park, MD 21146 |  |  |  |  |  |  |  |
| The modulate Cause (Final disease or condition resulting in details)    The modulate Cause (Final disease or condition resulting in details)   The modulate Cause (Final disease or condition resulting in details)  |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Inter |  |  |  |  |  |  |  |  |  |
| The proposed and the proposed  |  |  | Immediate Cause (Final disease a. ASDITYXI.d.  |  |  |  |  |  |  |  |  |  |
| We start the start of the start | maran da   | _  | Sequentially list conditions,  |  |  |  |  |  |  |  |  |  |
| We start the start of the start |  | mine   | cause. Enter Underlying Cause (Disease or injury that initiated  |  |  |  |  |  |  |  |  |  |
| past 12 months?    The past 12 months?   past 12 | cuted<br>nd<br>rransit   |  | events resulting in death) Last  |  |  |  |  |  |  |  |  |  |
| past 12 months?    The past 12 months?   past 12 | ),<br>be exec<br>sician a  | dica   | X UNPENDED AMENDED item#23a,27   | 7,28a-f,perME,g860, 10/24/   | 06 TT  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier  O.C.M.E.  July 10, 2006  30. Name and address of person who completed cause of death (Item 23a)  Theodore King MD. Assistant Medical Examiner  Theodore King MD. Assistant Medical Examiner  Theodore King MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32 Registrar's Signature  | 876(<br>ifficate<br>ng phys  |  | IF FEMALE. 23b. Was decedent pregnant in the   | cy   | 23d. Date of delivery                            |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier  O.C.M.E.  July 10, 2006  30. Name and address of person who completed cause of death (Item 23a)  Theodore King MD. Assistant Medical Examiner  Theodore King MD. Assistant Medical Examiner  Theodore King MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32 Registrar's Signature  | Box 6: death cerl  | nysicia  | Pregnant at time of death  |  |  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier  O.C.M.E.  July 10, 2006  30. Name and address of person who completed cause of death (Item 23a)  Theodore King MD. Assistant Medical Examiner  Theodore King MD. Assistant Medical Examiner  Theodore King MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32 Registrar's Signature  | , P.O. res that the signed by a detached   | ē  | Part II. Other significant conditions contributing to death but not resu   | Iting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier  O.C.M.E.  July 10, 2006  30. Name and address of person who completed cause of death (Item 23a)  Theodore King MD. Assistant Medical Examiner  Theodore King MD. Assistant Medical Examiner  Theodore King MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32 Registrar's Signature  | ords aw requi  | plete  |  |  | autopsy prior to completion of cause of          |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier  29c Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a)  Theodore King MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32 Registrar's Signature   | Rec<br>The la<br>ficate h  | 1 Yes 2 No 1 Yes 2 No                              |  |  |  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier  29c Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a)  Theodore King MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32 Registrar's Signature   | ital<br>sician:<br>s certi   | Be   | examiner? Hospital: 1 Innation: 3 4 55   |  |  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier  29c Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a)  Theodore King MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32 Registrar's Signature   | of V<br>ng Phy:<br>ofter thi   | -  | 27. Manner of Death 28a. Date of Injury 28   |  | 28d. Describe how injury occurred                |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier  29c Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a)  Theodore King MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32 Registrar's Signature   | ion<br>ttendir<br>feath<br>for: A  | atior  | Natural 5 Pending End 7/0/2006 1   | Find 3:39 pm 1 Yes 2 X No  | strap/harness                                    |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier  O.C.M.E.  July 10, 2006  30. Name and address of person who completed cause of death (Item 23a)  Theodore King MD. Assistant Medical Examiner  Theodore King MD. Assistant Medical Examiner  Theodore King MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32 Registrar's Signature  | Divis pital or A ours after or all pirec   | Sertific   | Suicide 6 Could not be 28e. Place of Injury - At home  | 28f. Location (Street and Number or Rural Route Number. City or Town, State) 352 Montecristo Court Gambrills, MD |  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier  O.C.M.E.  July 10, 2006  30. Name and address of person who completed cause of death (Item 23a)  Theodore King MD. Assistant Medical Examiner  Theodore King MD. Assistant Medical Examiner  Theodore King MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32 Registrar's Signature  | 29a Certifier (check only one) 29a Certifier (check one) 29a Certifier (check one) 29a Certifier (check one) 29a Certifier (check one) 29a Certifier (check one) 29a Certifier (check one) 29a Certifier (check one) 29a Certifier (check one) 29a Certifier (check one) 29a Certifier (check one) 29a Certifier (chec |  |  |  |  |  |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a)  Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year)  32 Registrar's Signature   | F 3 F 5  | 29b. Signature and title of certifier 29d Date sig |  |  |  |  |  |  |  |  |  |  |
| Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year)  32 Registrar's Signature   | Thousand, Thous  |  |  |  |  |  |  |  |  |  |  |  |
| otate  |  |  |  |  | 21201  |  |  |  |  |  |  |  |
| UUI A ' LVV ARRINAR I AN RINGER I  |  |  | 4 2 4 4 4  | Smarth of  |  |  |  |  |  |  |  |  |

|                                |  |                   | State of M   | Maryland           | -                      | artment of                            | Health and  |                                   | 20                   | 06          | 220                            | 967       |
|--------------------------------|--|-------------------|--|--------------------|------------------------|---------------------------------------|---|-----------------------------------|----------------------|-------------|--------------------------------|-----------|
|                                |  |                   | 1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death                                     |                    |                        |                                       |   |                                   |                      |             |                                |           |
|                                | Physici  | an                | Helen Brown  |                    | July                   | Day 2.0                               | Year<br>006   | 9:51                              | DМ                   |             |                                |           |
| 4                              | * /Medic<br>Examir   |                   | 4a Fecility Name (If not institution, give street and number   | 4b. City, Town, or |                        |                                       |   | 3.31                              | 111                  |             |                                |           |
| 1                              | Exami  | iei               | Annapolis Nursing & Re   |                    |                        |                                       | Annapo  | lis                               | Anne                 | Arur        | ndel                           |           |
|                                | Funeral  |                   | 5. Social Security Number 6. Sex 7. A  | If Under 1 Yea     |                        | 8. Date of Bir                        | th<br>Vocal   | 9. Birthpl                        | ace (State o         | or Foreign  |                                |           |
|                                | Director   |                   | 143-26-2869 <sup>1□ M</sup> 🎾 F  | 92                 | 2 Yrs.                 | Months Days                           | Hours Min.  | (Month, Da                        | 2 1913               | Mary        | n<br>11and                     |           |
|                                | P .  |                   | Usual Residence of Decedent  | 1.0 0              |                        |                                       |   |                                   |                      |             |                                |           |
|                                | anylar<br>show   | _ ,               | 10a. State 10b. County Maryland Anne Arundel   |                    | , Town or Lo           |                                       |   |                                   |                      | 10          | )d. Inside Ci<br>11☑ Yes       |           |
|                                | Ba-f   | Director          | -  | Al                 | nnapo                  |                                       |   |                                   | 40.000               |             |                                |           |
|                                | vith ti  |                   | 10e. Street and Number   |                    |                        | 10f. Zip Code                         |   |                                   | 10g. Citizen of V    | /hat Count  | ry?                            |           |
|                                | s 23   | Funeral           | 3230 Henson Ave  | at Ever in 11 S    | 12 1                   | 2140                                  |   | nacity Vac or No                  | USA<br>14 Bac        | e - America | n Indian                       |           |
|                                | iter de  | ű                 | 11. Marital Status  12. Was Deceden Armed Forces  1 □ Never Married 2 □ Married  1 □ Yes 2 □                     | s?                 | 1                      |                                       | Hispanic Origin? (S<br>ban, Mexican, Puer                                       | o Rican, etc.)                    | Blac                 | k, White, e |                                |           |
| 20                             | Irs af   | þ                 | If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates  | _                  |                        | 1□Yes 2XINo                           | Specify:  |                                   | Specify              | : ВЈ        | lack                           |           |
| ŏ                              | 72 hours after death with the Maryland<br>"naturel", or items 23e or 28a-f show<br>valical Evandoer must be notified at  | 8                 | 15. Decedent's Education   |                    | 16a. Deced             | dent's Usual Occu                     | pation  |                                   | 16b. Kind of Bu      | usiness/Ind | ustry                          |           |
| 215                            | within 7,<br>iana.<br>than "n  | ple               | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or                               | r5+)               | (Give<br>life. I       | kind of work done<br>DO NOT use retir | during most of wo   | rking                             |                      |             |                                |           |
| 21                             | 77 77  | Completed         | 7th 0  | .,                 | D                      | omestic                               | <b>_</b>  |                                   | Privat               | te Fa       | amily                          |           |
| b                              | al Hygir<br>I other  | Be (              | 17. Father's Name (First, Middle, Last)  |                    |                        |                                       | 18. Mother's Nar  | ne (First, Middle,                | , Maiden Sumam       | e)          |                                |           |
| yla                            | should be<br>and Mental<br>marked of   | P                 | Elijah Brown   |                    | 1                      |                                       | Mary J  | ane Ma                            | rshall               |             |                                |           |
| lar                            | 2 should be<br>and Menta<br>is marked<br>reumatic ev   |                   | 19a. Informant's Name/Relationship (Type, Print)   |                    |                        |                                       | at and Number or Ru   |                                   | -                    |             |                                |           |
| ď.                             | 1 and<br>Health<br>em 27   | 1                 | Gertrude E. McGowan(Nie  |                    | 1                      | Henson<br>sition (Name of             | n Ave An  | napoli                            | S, Md.               |             |                                |           |
| Ö                              | Pagas 1 a<br>nant of Her<br>int: If item<br>iry or othe  |                   | 20a. Method of Disposition 1 ☐ Buria! 2 【Cremation 3 ☐ Removal from State  | e ce               | m <i>etery</i> , cren  | natory or other pl                    |   |                                   |                      | •           |                                |           |
| Baltimore, Maryland 21215-0020 | bernit. Pagas 1 and 2 should be filad<br>Departmant of Health and Mental Hyg<br>mportant: If item 27 is marked othe<br>iny injury or other treumatic event,<br>2008. |                   | 4 Donation 5 Other (Specify)   | Met                |                        | remato                                | ***   |                                   | Baltimo              |             | Ma.                            |           |
| Ba                             | permit. Pagas<br>Departmant of<br>Important: If it<br>any injury or<br>once.   |                   | 21. Signature of Funeral Service Licensee  | 4                  | W                      | m. Rees                               | ess of Facility<br>Se & Son   | s Mort                            | uary, I              | .A.         |                                |           |
|                                | 50   |                   | Larry B, Beese Mc  |                    |                        |                                       | St. An  |                                   |                      |             | ) 1<br>Approximat              | ^         |
|                                | Dhysisian  |                   | 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each | line.              | . Do not ent           | er the mode of dy                     | ing, such as cardia   | or respiratory a                  | 11631,               | 1           | Interval Bet<br>Onset and I    | ween      |
|                                | Physician /Medical   |                   | Immediate Cause (Final   | 2                  | -100                   | m44 (                                 | androu  | u calla                           | 20.50                | 24 50       | 4-                             | - (0)     |
| ĥ                              | Examiner   |                   | disease or condition resulting in death)   | Due to (or         | as a consec            | uence of):                            | BHONON  | CLS CVIN                          | 16 12130             | 45          | ı                              |           |
|                                | ъ .∺   | ner               |  |                    |                        | ,                                     |   |                                   |                      |             |                                |           |
|                                | cata ba exacutad<br>physician and<br>tha bunal-transit   | Examiner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying                               | Due to (or         | es e conseq            | uence of):                            |   |                                   |                      |             |                                |           |
| 8760,                          | ba ey<br>ician<br>burial   |                   | Cause (Disease or injury   |                    |                        |                                       |   |                                   |                      |             |                                |           |
| 687                            | phys<br>phys<br>s tha  | Physician/Medical | that initiated events resulting in death) Last   |                    |                        | Į<br>L                                |   |                                   |                      |             |                                |           |
|                                | daath certific<br>a attanding p<br>ed for usa as   | Š                 | d  |                    |                        |                                       |   |                                   |                      |             |                                |           |
| Box                            | attar<br>d for   | cla               | Dot II. Other circuitinest conditions contributing to doth   | but not rocul      | Iting in the           | adorluina aouso a                     | ivon in Port I  | 23h Did                           | tobecco use cor      | atribute to | the cause i                    | of death? |
| P.O.                           | tha c<br>by tha  | hys               | Part II. Other significent conditions contributing to death  | P -                | ining in the th        | idenying cease g                      | iveiriii Fatti.   |                                   | Yes 2□ No            | 3 ☐ Prob    |                                | Onknown   |
|                                | s that tha<br>ned by th<br>e detach  | by P              | Dements, 11/2  | 401                | 1401                   |                                       |   |                                   | 103 20110            | 0           |                                |           |
| ğ                              | law raquires that tha daath certific<br>as baen signed by tha attanding p<br>t 2 should be detached for usa as   | ed                | Duckete Res  | -11                | m 1/1                  | , fri                                 |   |                                   | an autopsy<br>ormed? |             | re autopsy f<br>ilable prior t |           |
| ဝ၁                             | 2 0 N  | Completed         | Mayers /(14  | 4 (                | 70 (0                  | 1154                                  | ry  | porte                             | illou:               | com         | pletion of c<br>eath?          | ause      |
| ž                              | m - m  | E                 | Itnpertension)   | )                  |                        |                                       |   | 10                                | Yes 2 No             | 1 🗆         | Yes 2□                         | No        |
| ita                            | ilcian: The<br>cartificata<br>rector, pag  | Be (              | 25. Was case referred to medical examiner?   |                    |                        |                                       | 26. Place of Dea  | ath (Check only o                 | one)                 |             |                                |           |
| 7                              | hysto<br>his ca<br>il dire   | 2                 | 1 Yes 2 No Hospital: 1 Inpat   |                    | ER/Outpatien           | I 3L DOA                              |   |                                   | dence 6 □Oth         |             | )                              |           |
| ח                              | ing P  | 5                 | 27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, D  | jury<br>Jay Year)  | 28b. Time of<br>Injury | W                                     |   | 28d. Describe how injury occurred |                      |             |                                |           |
| Sic                            | Attending<br>ir daath.<br>ector: Aftar<br>by the fune  | icat              | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be  | niunc At hor       | mo form etr            | eet, factory, office                  | M 1 Yes 2 No  |                                   |                      | Route Num   | her                            |           |
| Division of Vital Records,     | aftar<br>Direc   | Certification:    | 4 Homicide determined 286. Place of it building, 6   | etc. (Specify)     | )                      | ser, ractory, office                  | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |                                   |                      |             |                                |           |
| _                              | spital   | aic               | 29a. Certifier 1 Certifying Physician: To the bes  | t of my know       | /ledge, death          | occurred at the t                     | ime, date and place   | , and due to the                  | cause(s) and ma      | nner as sta | ited.                          |           |
|                                | To the Hospital or Attending Physician: within 24 hours aftar daath. To the Funeral Director: Attar this cardifoc complataly filled in by the funeral director,      | edicai            | (Check only one) 2 ☐ Medical Exeminer: On the basis and manner s   |                    | on end/or inv          |                                       |   | rred at the time,                 |                      |             |                                | 5}        |
|                                | Vith<br>Tot  | Σ                 | 29b. Signature and title of certifier  | 2                  |                        | 29c. Licer                            | ise number  |                                   | 29d. Date signed     | I (Month, D | Day, Year)                     |           |
|                                |  |                   | 1 Janeline   | Vo                 | 2ech                   | V U                                   | 010   | 12                                | 7 000                | -4 5        | 006                            |           |
|                                |  |                   | 30. Name and address of person who completed cause of  | death (Item        | 23a) (Type,            | Print                                 | ochum   | DUM                               | 4 a The              | 3.71        | _ 1/1                          | )         |
|                                | Sta  | te                | 31. Date filed (Month, Day, Year) 32 Regis   | strar's Signatu    | nte 7                  | y ofer                                | 20019   | · vicit                           | 1 - 013              | >0(11)      | S                              | D,        |
|                                | Sta<br>Registr   |                   | JUN 0 6 2006   | a de               | h                      | will !                                |   |                                   |                      | •           | 0)                             | 51        |

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 5 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July **Physician** 2006 5:20A M Corrine Ecker Bohn /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll 477 Union Bridge Rd. Union Bridge 8. Date of Birth (Month, Day, Year) Jan. 30, 1 7. Age (In yrs. last birthday) If Under 1 Year II Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🗷 F 70 Yrs 220-32-3169 Director Usual Residence of Decedent the Maryland 10c. City Town or Location 10d. Inside City Limits 10a State 10h County 28a-f ehow other traumatic event, the Medical Examiner must be nutified at 1 ☐ Yes 2X No Directo Union Bridge Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "marked ot Items 23s or 21791 477 Union Bridge Rd. U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 【XNo Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) sewing factory seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Dickensheets Herbert E. Ecker ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4650 Sundown Dr. Richard A. Bohn/ son Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/8/2006 Church of God Cem. Uniontown, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Fufferal Service Lice E. Broadway Union Bridge, MD 21791 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ADENOCAR CINOMA PANCREATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner anding physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. Il yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. F 9 Unknown been signed is should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by POTHYRO (DISM 1 Yes 2 No 3 Probably 4 Monknown LAPAROTOMY 24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 No EXLORATORY 24a. Was an certificate 2 1 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death [Check only one] Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this. After this funeral of 28a. Date ol Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Director: A investigation 2 Accident Director: , 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of a rtifle

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

M-D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Gerald O. Boyce 0342 M 04 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner KENINSHLA REGIONAL MEDRAL CLNTZ SAUSBURY HICOMICO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 173-32-5690 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **™** M 2□ F 63 Director Usual Residence of Decedent with the Maryland 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other then "naturel", or items 23s or 28s-1 show or other traumatic event, the Madical Examinar must be exutified at PA York County York 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17402 182 Oak Manor Drive USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □X/es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. Int: If item 27 ie marked other then "! Elementary/Secondary (0-12) College (1-4or 5+) Set-up adjuster/machineary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oliver Boyce Myrtle Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah D. Boyce - Wife 182 Oak Manor Dr., York, PA 17402 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Heffner Funeral 20a. Method of Disposition Date 20c. Location - City or Town, State July 7, 2006 1551 Kenneth Road 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) York, PA 17408 Inc Chape1 δ. Crematory, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Holloway Funeral Home Professional Association Kell 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary Hemorrhage **Physician** /Medical Due to (or as a consequence of) Examiner hrombocytopouro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ng physician and as the burial-transit resulting in death) Last Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical signed by the attending d be detached for use as 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? VERWOOLG 1 ☐ Yes 2 No 3 Probably 4 Unknown Emphysems 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Anemia 1 Yes 2 No 1□ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 1 ☐ Yes 2 No 1/1 Inpatient Other: 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ctor: After this y the funeral o 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospitel or Attendi within 24 hours after death.
To the Funerel Director: A completely filled in by the fu 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cull not 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 0 2006 Registrar

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|   | 1              | For State Registrar  | State of M                                   | 1aryland         |               | rtment of H                         | lealth and N<br>Death          |  | giene<br>Reg. No. | 006                  | 22970                            |
|---|----------------|--|--|------------------|---------------|-------------------------------------|--------------------------------|--|-------------------|----------------------|----------------------------------|
|   | -              | Decedent's Name (First, Middle, Landson)   | ast)   |                  |               |                                     |                                | 2. Date of De                          | ath               | Year                 | 3. Time of Death                 |
| Physician   |                | Clara  | M.   | Ban              | ks            |                                     |                                | July                                   | 4 20              | 06 Year              | 7:45 PM <sup>M</sup>             |
| /Medical  |                | a. Facility Name (If not institution, gi   | ve street and numbe                          | r)               |               | 4b. City, Town, o                   | r Location of Death            |  | 4c. Co            | unty of Death        |                                  |
|   |                | Wicomico Nursi   | ng Home                                      |                  |               | Salish                              | oury                           |  |                   | comico               |                                  |
| Funeral   | - }            | 5. Social Security Number 6.   |  | ige (In yrs. las |               | If Under 1 Year<br>Months Days      | If Under 24 Hrs.<br>Hours Min. | 8. Date of Bir<br>(Month, Da<br>5/16/1 | th<br>ay, Year)   | 9. Birth             | place (State or Foreign<br>ntry) |
| Director  | -              | 213–16–7490  | 10 M 28 F                                    | 84               | Yrs.          |                                     |                                | 5/16/1                                 | 922               | Mar                  | yland                            |
| Pu &  | -              | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City.       | Town or Lo    | cation                              |                                |  |                   |                      | 10d. Inside City Limits          |
| sho   |                |  | ni ao  |                  | isbur         |                                     |                                |  |                   |                      | 1 □Yes 2 No                      |
| with the Marylan or 28a-1 show  | 2              | Maryland Wicor   | 1100   | bal              | IBDUL.        | 10f. Zip Code                       |                                |  | 10g. Citizen      | of What Cou          | intry?                           |
| 15-0036  72 hours after death with the Maryland  "natural", or Items 23a or 28a-f show selfcal Examinar must be notified at   |                | 30189 Johnson Ro   | oad  |                  |               | 21804                               |                                |  | US                |                      |                                  |
| Sitter death viriler death virilers 23s   | 2              | 11. Marital Status   | 12. Was Deceder                              |                  | 13. V         | Vas Decedent of H                   | lispanic Origin? (Sp           | pecify Yes or No                       |                   | Race - Amer          |                                  |
| fter d  | 3              | 1 ☐ Never Married 2 ☐ Married  | Armed Force                                  |                  | 1             |                                     | an, Mexican, Puerto            | o Rican, etc.)                         |                   | Black, White         |                                  |
| Urs a urs a by  | 2              | 3 XWidowed 4 □ Divorced  | If Yes, Give<br>Year or Dates                | s:               |               | I□Yes 2 <b>⊠</b> No                 | Specify:                       |  | Sp                | ecify: wh            | ite                              |
| 21215-0036 ed within 72 hours all ygiene. Then "natural", or it, the Modical Exam.  | 2              | 15. Decedent's 1   | Education                                    |                  |               | lent's Usual Occup                  | pation<br>during most of work  | kina                                   | 16b. Kind         | of Business/Ir       | ndustry                          |
| <b>717</b>  | 2              | Elementary/Secondary (0-12)  | College (1-4o                                | r 5+)            | life. L       | DO NOT use retire                   | d)                             | Ü                                      | 01 - 4            | da din ari N         |                                  |
| Se y y y y y  | 3              |  | _  |                  | Seam          | stress                              | 18. Mother's Nam               | no (Firet Middle                       |                   |                      | lanufacturin                     |
| laryland 21215-0036 2 should be filed within 72 hours after death wi and Mental Hygiene. Is marked other than "natural", or Items 23a aumstic event, the Modical Examinar must be 70 Re Completed by Filmeral I   | 0              | 17. Father's Name (First, Middle, Las<br>Carlton Hastin  |  |                  |               |                                     |                                | tewart                                 | , Maiden Su       | mame)                |                                  |
| Vaarke narke  | 2              |  |  |                  | 10h Mailia    | - Address (Ctrost                   | and Number or Ru               |  | or City or To     | oum State 7          | n Codel                          |
| Mar<br>Mar<br>12 sh<br>h and<br>r is m  | 1              | 19a. Informant's Name/Relationship Kenneth D. Banks  |  |                  | 30: Mailin    | 819 Johns                           | son Rd.,                       | Salisbu                                | ry, ME            | )<br>)               | p C004)                          |
| e, P. I and | -              | 20a. Method of Disposition   |  | 20b. Pla         |               | sition (Name of                     |                                | Date                                   |                   | ion - City or T      | own. State                       |
| Orogen Street   |                | 1 Burial 2 □ Cremation 3   |  | te cen           | netery, cren  | natory or other pla                 | <sup>сө)</sup> 7/8,            | /06                                    |                   | n, MD                |                                  |
| altimore mit. Pages 1 mpthment of He portant: If iten yinjury or oth  | ŀ              | '4 □Donation 5 □ Other (Spec   |  | AI               |               | emetery                             |                                |  |                   |                      |                                  |
| Baltimore, Maryland 212: parmit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: if them 27 is marked other than any injury or other traumetic event, it employed.  |                | 21. Signature of Funeral Service of  | teroses (                                    | FSP              | 5             | 01 Snow 1                           | Hill Rd.,                      | Salisb                                 | ury, M            | onal A<br>D 2180     | ssociation<br>4                  |
| *   |                | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on   | mplications that caus<br>y one cause on each | ed the death.    | Do not ent    | er the mode of dyir                 | ng, such as cardiac            | or respiratory a                       | arrest,           |                      | Approximate<br>Interval Between  |
| Physician   |                | Immediate Cause (Finaf disease or condition  | SEP  | 212              |               |                                     |                                |  |                   |                      | Onset and Death                  |
| /Medical  |                | resulting in death)  | Que to (or                                   | as a conseque    | ence of):     |                                     |                                |  |                   |                      |                                  |
| Examiner  |                | Sequentially list conditions   | b. KESP                                      | 11-1-1           | Ry            | FAILUR                              | £.                             |  |                   |                      |                                  |
| P = 2   | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   | Due to (or                                   | as a conseque    | ence of):     |                                     | *                              |  |                   |                      |                                  |
| executed executed in and in-transit   | E              | Cause (Disease or injury that initiated events resulting in death) Last  | c. Due to (es                                | as a conseque    | nan of):      |                                     |                                |  |                   | -                    |                                  |
| 8760, cate be executed by sician and the burial-transit   |                | Tooling in document of the control o | Due to (0)                                   | as a conseque    | silce or).    |                                     |                                |  |                   |                      |                                  |
| 8760, cate be exphysician the burian  | alcai          | •  | d  |                  |               |                                     |                                |  |                   |                      |                                  |
| 8 8 8   | Me             | IF FEMALE:   | 23c. If yes, outcor                          | ne of pregnan    | CV            |                                     |                                |  | 224               | I. Date of deliv     | (07)                             |
| Bo<br>auth c  | Pnysician/me   | 23b. Was decedent pregnant in the past 12 months?  | 1 ☐ Live birth                               | 2 Fetal of       | death 3□      | Ectopic pregnanc<br>Other (specify) | у                              |  | 230               | Month                | Day Year                         |
| O the de shed shed shed shed shed shed shed   | ysic           | 1 ☐ Yes ♥☑No<br>9 ☐ Unknown  | 9□ Unknowr                                   |                  | 107 3         |                                     |                                |  | ,                 |                      |                                  |
| ds, P.O. E uires that the des   | 5              | Part II. Other significant conditions  | contributing to death                        | but not result   | ting in the u | nderlying cause giv                 | ven in Part I.                 | 23e. Did                               | tobacco use       | contribute to        | the cause of death?              |
| d be d be   | S C            |  | -  |                  |               |                                     |                                | 1 🗀                                    | Yes PON           | No 3 Pro             | bably 4 Dunknown                 |
| Division of Vital Records, P.O. Box or Attending Physician: The law requires that the death certained after death.  Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use   | Completed      |  |  |                  |               |                                     |                                | 24a. Wa                                | s an 2            | Ah Were aut          | opsy findings available          |
| Aec lav has pe 2  | E              |  |  |                  |               |                                     |                                | auto                                   | opsy<br>ormed2    | prior to c<br>death? | ompletion of cause of            |
| Vital Rec   |                |  |  |                  |               |                                     | 00 Plant (Par                  | 1 Yes                                  | 2 No              | 1 🗆 Yes              | 2 ∐ No                           |
| Vit<br>Bicial<br>certil   | ng<br>C        | 25. Was case referred to medicat examiner?  1 Yes 2 No   | Hospitaf:                                    | otions 200       | D/Outpation   | nt 3 DOA Ott                        | 26. Place of Dea               |  |                   | Other (Spec          | ifu)                             |
| Of<br>Physical discrete of  | 0              | 27. Manner of Death  | 28a. Date of f                               | niury 2          | 28b. Time o   |                                     |                                | 28d. Describe                          |                   |                      | 1197                             |
| On<br>ding<br>ding<br>th.   | tio            | Natural 5 Pending 2 Accident investigat  |  | Day Year)        | Infury        |                                     | rk?<br>]Yes 2 □No              |  |                   |                      |                                  |
| Atten deal deal octor   | lica           | 3 ☐ Suicide 6 ☐ Could not  | be 28e. Place of                             | Injury - At hon  | ne, farm, str | eet, factory, office                |                                | 28f. Location                          | (Street and N     | lumber or Ru         | ral Route Number,                |
| Div   | Certification: | 4 Homicide   | building,                                    | etc. (Specify)   |               |                                     |                                | City or 10                             | iwn, State)       |                      |                                  |
| spita<br>iours<br>neral   | a              | 29a. Certifier 1 Certifying  | Physician: To the be                         | st of my know    | rledge, deat  | h occurred at the ti                | me, date and place             | a, and due to the                      | cause(s) an       | d manner as          | stated.                          |
| Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification ompletely filled in by the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director is the funeral director.   | edicai         | (Check only 2 Medical Ex   | aminer: On the basis<br>and manner           |                  | on and/or in  | vestigation, in my                  | opinion, death occu            | irred at the time                      | , date and pla    | ace, and due         | to the cause(s)                  |
| To th<br>Mithin<br>To th<br>comp  | M              | 29b. Signature and title of certifier  | $\wedge$                                     |                  |               | 29c. Licen:                         |                                |  | 29d. Date s       | igned (Month         | , Day, Year)                     |
| -4  | ļ              | > Mel  | X Ca   |                  |               | 1) 0                                | 006319                         | 19.                                    | 7/6               | 6 06                 |                                  |
| Was a series of the series of |                | 30. Name and address of person wh  | o completed cause of                         | of death (ftem   | 23а) (Туре,   | Print)                              |                                |  |                   |                      |                                  |
| 10  |                | Yogesh Vohra   | 4.D. 614                                     | Easte            | rnsho         | re Dr Sa                            | lisbury M                      | D 21804                                |                   |                      |                                  |
| State   | е              | 31. Date filed (Month, Day, Year)  | 32. Reg                                      | istrar's Signatu | ıre           |                                     |                                |  |                   |                      |                                  |
| Registra  | ır             | JUL 0 7  | 2006   | 11225            | H. Jo         | me                                  |                                |  |                   |                      |                                  |

DHMH 17 Rev 1/2001

|                     |  |                  | For  | State of Maryla   | nd / Depa               | artment of He                                | ealth and M                                 | ental Hygi                                   | ene) nns                                  | 22971   |
|---------------------|--|------------------|--|---|-------------------------|--|---|--|---|---|
|                     |  |                  | 1 - State<br>Registrar   |   | Ce                      | rtificate of D                               | Death                                       |  | 3. No.                                    | En En W 1 1   |
| П                   | Physicia   | an               | Decedent's Name (First, Middle, Last)  | Baker   |                         |  |   | 2. Date of Death<br>Month                    | Day Year                                  | 3. Time of Death                                    |
| 6                   | /Medic   |                  | 4a. Facility Name (If not institution, give s                                      | 000   |                         | 4b. City, Town, or I                         | Location of Death                           | July C                                       | 200 (<br>4c. County of Dear               |   |
|                     | Examili  | ei               | A 1 1 .  | eat the   | Lake                    | Salisb                                       | urv   |  | Wicom                                     | nic D   |
|                     | Funeral  |                  | 5. Social Security Number 6. Sex   |   | s. last birthday)       | If Under 1 Year<br>Months Days               | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birth<br>(Month, Day)<br>6/18/196 | (ear) 9. Birt                             | hplace (State or Foreign<br>funtry)<br>ryland       |
|                     | Director   |                  | 212-78-7068  | 1101 2021 44  | Yrs.                    |  |   | 6/18/196                                     | oz Ma                                     | ryland  |
|                     | yland<br>yland   |                  | 10a. State 10b. County   | 10c. C  | city, Town or Lo        | ocation                                      |   |  |   | 10d. Inside City Limits                             |
|                     | Ba-f el  | ctor             | Maryland Wicomic   | o Sa  | lisbury                 | 7  |   |  |   | 1X Yes 2 No   |
|                     | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "naturel", or Iteme 23a or 28a-f ehow<br>ont, the Madical Exam ar must be notified a  | Funeral Director | 408 Deborah Dr.,   | Apt. F  |                         | 10f. Zip Code<br>21804                       |   | 109  | g. Citizen of What Co<br>USA              | ountry?   |
|                     | teme   | uner             |  | 12. Was Decedent Ever in<br>Armed Forces?                 | U.S. 13.                | Was Decedent of His<br>If Yes, specify Cuban | spanic Origin? (Spe<br>n, Mexican, Puerto F | cify Yes or No-<br>Rican, etc.)              | 14. Race - Ame<br>Black, Whit             |   |
| 36                  | irs afte   | by F             | 1 Never Married 2 Married 3 Widowed 4 XDivorced                                    | 1 ☐ Yes 2 ☐ <b>X</b> No<br>If Yes, Give<br>Year or Dates: |                         | 1 □ Yes 2 □ Ko                               | Specify:                                    |  | Specify: W                                | nite  |
| 2-0                 | 72 hou   | ted              | 15. Decedent's Edu<br>(Specify only highest grade                                  |   | 16a. Dece               | dent's Usual Occupat                         | tion  | 10   | Sb. Kind of Business                      | Industry  |
| 21                  | Aithin 7   | Completed        | Elementary/Secondary (0-12)  | College (1-4or 5+)  | life.                   | DO NOT use retired)                          | anny most of month                          | .9   | Optical                                   |   |
| d 21                | Hygier<br>ther ti  |                  | 12 17. Father's Name (First, Middle, Last)   | <u>T</u>  | De                      | te Entry                                     | 18. Mother's Name                           | (First, Middle, Ma                           |   |   |
| lan                 | Aental<br>Aental<br>rked o   | To Be            | James Edward Bak   | er  |                         |  | Marjorie                                    |  |   |   |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or Iteme 23a or 28a-f show way injury or other traumatic event, the Mudical Examiner must be notified at once.  |                  | 19a. Informant's Name/Relationship (Ty<br>James E. Baker/fat                       |   |                         | ng Address (Street ar<br>99 Homeste          |   |  |   |   |
| Baltimore,          | ages 1 and to the trial of them of them of them of them of the trial of the trial of the trial of the trial of the trial of the trial of the trial of the trial of the trial of the trial of tri |                  | 20a. Method of Disposition  1 ☐ Burial 2 🛣 Cremation 3 ☐ P                         | emoval from State   | cemetery, cre           | osition (Name of matory or other place       | "   |  | oc. Location · City or                    |   |
| altin               | artme<br>cortan<br>injury  |                  | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License         |   |                         | Cremator                                     |   |  | Salisbury<br>Sesional                     |   |
| ñ                   | De la personal   | 9                | David H. Lan   | neon CF   | SP                      | 501 Snow                                     | Hill Rd.,                                   | Salisbu                                      | ry, MD 21                                 | Association<br>804                                  |
|                     |  |                  | 23a. Part1. Enter the disease, or compleshock, or heart failure. List only or      | cations that caused the de-<br>ne cause on each line.     | ath. Do not en          | ter the mode of dying                        | , such as cardiac o                         | r respiratory arres                          | st,                                       | Approximate<br>Interval Between<br>Onset and Death  |
|                     | Physician  |                  | Immediate Cause (Final disease or condition resulting in death)                    | Circhosis   | of                      | the LI                                       | ver   |  |   | Oriset and Oeath                                    |
|                     | /Medical<br>Examiner   |                  | Tosoling in obdiny   | Due to (or as a conse                                     | equence of):            |  |   |  |   |   |
|                     |  | Jer              | Sequentially list conditions, it any, leading to immediate cause. Enter Underlying | Due to (or as a conse                                     | squance of):            |  |   | · · · · · · · · · · · · · · · · · · ·        |   |   |
|                     | cuted<br>nd<br>ransit  | Examiner         | that initiated events  |   |                         |  |   |  |   |   |
| 760,                | te be executed<br>ysicien and<br>ne burial-transit   | cai Ex           | resulting in death) Last   | Due to (or as a conse                                     | equence of):            |  |   |  |   |   |
| 687                 | 2 > 2  |                  |  | 1   |                         |  |   |  |   |   |
| Box (               | h certii<br>anding<br>use a  | M/W              | IF FEMALE:<br>23b. Was decedent pregnant   | 3c. If yes, outcome of preg<br>1 ☐ Live birth 2 ☐ Fe      |                         | Ectopic pregnancy                            |   |  | 23d. Date of de                           |   |
| .O. B               | that the death certifical<br>ed by the ettending phi<br>detached for use as th   | Physician/Med    | in the past 12 months?<br>1 □ Yes 212 No<br>9 □ Unknown                            | 4 Pregnant at time of<br>9 Unknown                        |                         | Other (specify)                              |   |  | Month                                     | Day Year  |
| <b>a</b>            | res that t<br>ilgned by<br>be detac  | by Ph            | Part II. Other significant conditions con  | ntributing to death but not re                            | esulting in the u       | inderlying cause giver                       | n in Part I.                                | 23e. Did toba                                | acco use contribute to                    | the cause of death?                                 |
| ords                | w require<br>been sig<br>should b  |                  |  |   |                         | ··   |   | 1 🗆 Yes                                      | 2 2 No 3 □ PI                             | robabły 4 🗆 Unknown                                 |
| Vital Records,      | The lay  | Completed        |  |   |                         |  |   | 24a. Was an autopsy perform                  | prior to                                  | utopsy findings available<br>comulation of cause of |
| ital                |  | BeC              | 25. Was case referred to medical examiner?   | ,   |                         |  | 26. Place of Death                          | -  |   | 7   |
| of V                | S S  | 2                | 1 Yes 2 No   |   | ER/Outpatie             |  | 4   Nursing non                             |  | ce 6 ☐Other (Spe                          | cify)   |
|                     | ding P.<br>After<br>funer  | tlon             | 27. Manner of Teath  12Natural 5 Pending investigation                             | 28a. Date of Injury<br>(Month, Day Year)                  | 28b. Time o<br>Injury   | Work'  | at<br>?<br>′es 2 □ No                       | 28d. Describe hov                            | rinjury occurred                          |   |
| Division            | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral  | Certification:   |  | 28e. Place of Injury - At building, etc. (Spec            | home, farm, st<br>cify) |  |   | 28f. Location (Stre<br>City or Town,         | eet and Number or R<br>State)             | ural Route Number,                                  |
|                     | Hospital   | al Ce            | 29a. Certifier Certifying Phy  | sician: To the best of my k                               | nowledge, deat          | th occurred at the time                      | e, date and place, a                        | and due to the cau                           | use(s) and manner as                      | s stated.   |
|                     | To the Ho<br>within 24 th<br>To the Fu<br>completely   | Medical          | one)   | ner: On the basis of exami<br>and manner stated.          | nation and/or in        | 29c. License                                 |   |  | e and place, and due d. Date signed (Mont |   |
|                     | 5 W T 20   | -                | 29b Signature and title of conflict  | 24/ N   | un                      | 1  |   |  |   |   |
|                     | Jan  | 1                | 30. Name and address of person who co  | ompleted cause of death (It                               | em 23a) (Type,          | Print)                                       | 21 hours                                    | 2 (.)  | /1/ 10A                                   | 21802   |
|                     | ()<br>Sta  | ate.             | 31. Date filed (Month, Day, Year)  | 32. Registrar's Sig                                       | nature                  | 405/14 P                                     | 10 BOX173                                   | ) 101  | ) PO ED                                   | , , , , ,   |
|                     | Regist   |                  | .11.   | 106 Segue   | H. 1                    | bash   |   |  |   |   |

| _                   |  |                  | 1 - For<br>State<br>Registrar  | State of Maryland  |                                | artment of H  |   | F   | leg. No.  | 22972   |
|---------------------|--|------------------|--|--|--------------------------------|---|---|---|---|---|
|                     | Physici<br>/Medio  |                  | Decedent's Name (First, Middle, Las  | Betty Carro  | 11 B                           | ennett  |   | 2. Date of Dea<br>Month<br>July           | Day Yeer<br>13. 2006  | 3. Time of Death 5:17 A <sup>M</sup>                  |
|                     | Examin   |                  | 4a. Facility Name (If not institution, give 215 Liberty Roas 5. Social Security Number 6. Second Security Number 6. Second Security Number 8. Second Security Number 8. Second Security Number 8. Second Security Number 8. Second Security Number 8. Second Second Security Number 8. Second Security Number 8. Second Security Number 8. Second Security Number 8. Second Security Number 8. Second Security Number 8. Second Security Number 8. Second Second Security Number 8. Second Security Nu | ad   | ast birthdav)                  | Feder   | Location of Death alsburg                             | 8. Date of Birtl                          | 4c. County of Dea   | ne  |
|                     | Funeral<br>Director  |                  | 215-20-0417 1<br>Usual Residence of Decedent   | □ M 2¢D¥F 81   | Yrs.                           | Months Days   | Hours Min.  | (Month, Day                               | 17,1924 Mai   | thptace (State or Foreign<br>ountry)<br>ryland        |
|                     | ne Maryian<br>8a-f ehow  | ctor             | MD Carol   |  | Fe                             | deralsb   | urg   |   |   | 10d. tnside City Limits<br>1 ☑ Yes 2 ☐ No             |
|                     | ath with the 234 or 2  | Funeral Director | 10e. Street and Number 215 Liberty Ro  |  |                                | 10f. Zip Code 216.  |   | Ţ   | Inited St   | ates  |
| 900                 | 72 hours after death with the Maryland<br>neturel', or items 23s or 28s-1 ehow<br>disal Evandrar must be notified at   | þ                | 11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  | 12. Was Decedent Ever in U.S<br>Armed Forces?<br>1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates:  |                                | Was Decedent of Hi<br>fYes, specify Cuba<br>1 □ Yes 24□kNo                    | ispanic Origin? (Sp<br>n, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)          | 14. Race - Ame<br>Black, Whit<br>Specify: W                 | te, etc.  |
| Maryland 21215-0036 | be filed within 72 hours after death with the Marylan<br>hal Hyglene.<br>Id other than "neturel", or itema 23a or 28a-1 show<br>event, it a Madical Examinar must be motified at | Completed        | 15. Decedent's Ed<br>(Specify only highest gra<br>Elementary/Secondary (0-12)<br>1 2   |  | (Give<br>life.                 | dent's Usual Occupa<br>kind of work done o<br>DO NOT use retired<br>istrative | during most of work<br> }                             |   | Insurance Dental Of:  | Agency/   |
| yland ;             | should be filed<br>and Mental Hyg<br>marked othe<br>umatic event,  | To Be C          | 17. Father's Name (First, Middle, Last)  James H. Can  | rroll  |                                |   | 18. Mother's Nam<br>Venus                             | e (First, Middle,<br>Murphy               | Maiden Sumame)  |   |
| ore, Mar            | ss 1 and 2<br>of Health a<br>litem 27 ic   |                  | 19a. Informant's Name/Relationship (7 William P. Ben 20a. Method of Disposition 19 € Surial 2 □ Cremation 3 □  | nett/Spouse  | 215<br>ace of Dispo            | Liberty sition (Name of matory or other place                                 | Road,   | Federa<br>Date                            | r, City or Town, State,  1sburg, N  20c. Location - City or | MD 21632  |
| Baltimore,          | permit. Pages<br>Department of I<br>Importent: If It<br>any injury or o  |                  | 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen   | Eas  | 22                             | Sh. Vet. (<br>Name and Addres<br>16 N. Ma                                     | ss of Facility Fr                                     | amptom                                    |   | Maryland Home, P.A.                                   |
|                     | Physician<br>/Medical<br>Examiner  |                  | 23a. Part1. Enter the disease, or companies, or heart failure. List only disease or condition resulting in death)  Secuentially list condition if any, leading to immediate  | a. Spring C  a. Jie to (or as a consequence)   | Do not ent                     | er the mode of dying  | g, such as cardiac                                    | or respiratory ari                        | est,  | Approximate Literal Between Literal and Death         |
| 8760,               | icate be executed<br>physicien and<br>s the burial-transit   | dical Examiner   | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | C. Due to (or as a consequence of the consequence o |                                |   |   |   |   |   |
| P.O. Box 6          | the death certify the attending ched for use as  | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal ( 4 □ Pregnant at time of decoration)   | death 3                        | Ectopic pregnancy Other (specify)   |   |   | 23d. Date of del<br>Month                                   | ivery<br>Day Year                                     |
|                     | law requires that<br>as been signed b<br>2 should be deta  | þ                | Part II. Other significant conditions or   | ontributing to death bul not resul   | Iting in the u                 | nderlying cause give  | en in Part I.   |   | bacco use contribute to                                     | o the cause of death?                                 |
| al Records,         | The ate h  | Completed        |  |  |                                |   |   | 24a. Was a<br>autops<br>perfor<br>1 ☐ Yes | med? prior to death?  | utopsy findings available completion of cause of 2 No |
| Σ                   | Physicien: Tribis certificates director, pr  | o Be             | 25. Was case referred to medical examiner?  1 Yes 2 No   | Hospital: 1 ☐ Inpatient 2 ☐ 8  | ER/Outpatien                   | t 2000 Othe   | 26. Place of Deatl                                    |   |   |   |
| Division of Vital   | After<br>Aune  | atlon: To        | 27. Manner of Death  1 Matural 5 Pending 2 Accident investigation  | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury         | 28c. Injury<br>Work   | 4 LINUISING NO  |   | ence 6  ☐ Other (Specow injury occurred                     | city)   |
| Dİ                  | or Al  | Certification:   | 3 Suicide 6 Could not be determined  | building, etc. (Specify)   | )                              |   |   | City or Tow                               |   |   |
|                     | To the Hoepital within 24 hours a To the Funerel Completely filled   | Medical          | one)   | ysician: To the best of my know<br>niner: On the basis of examinati-<br>and manner stated.   | vledge, death<br>ion and/or in | estigation, in my op  | oinion, death occur                                   | ed at the time, d                         | ate and place, and due                                      | to the cause(s)                                       |
|                     | Miwit<br>To<br>Do  | _                | 29b. Signature and title of certifier  | SUM  |                                | 29c License   | 7857  |   | 19d. Date/signed (Month                                     | 6-  |
|                     |  |                  | 30. Name and address of person who of 29466 Finfail De   | completed cause of death (Item   | 23a) (Type,                    | MD 216  | 01  |   | /   |   |
|                     | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signatu  | ure                            | Alexand I   |   |   |   |   |

|                            |   |                | For<br>State<br>Registrar   | State o                       | of Maryland  |                               | artment of H                                    |                               | nd Mental Hy                                       | giene<br>Reg. No.        | 200                           | 6 22973                           |
|----------------------------|---|----------------|---|-------------------------------|--|-------------------------------|---|-------------------------------|--|--------------------------|-------------------------------|-----------------------------------|
|                            |   |                | 1. Decedent's Name (First, Middl  | e, Last)                      |  |                               |   |                               | 2. Date of De                                      | ath                      | V                             | 3. Time of Death                  |
|                            | Physici:<br>/Medic  |                | Mila Jean Beh   | lke                           |  |                               |   |                               | Month May 9  | Day                      | Year<br>2006                  | 5 17:30 R                         |
| 1                          | Examin  |                | 4a. Facility Name (If not institution   | n, give street and nu         | mber)  |                               | 4b. City, Town, or                              | Location of                   | Death  | 4c. C                    | ounty of Dea                  | th                                |
|                            |   |                | Peninsula Reg   | ional Medi                    | ical Cen   | ter                           | Salisb  | ury                           |  | Wi                       | comico                        |                                   |
|                            | Funeral   |                | 5. Social Security Number   | 6. Sex<br>1 ☐ M 2 🕱 F         | 7. Age (In yrs. I  |                               | If Under 1 Year<br>Months Days                  | If Under 2                    | Min. (Month, Da                                    | iy, Year)                | C                             | thplace (State or Foreign ountry) |
|                            | Director  |                | 220-28-2577   | 1 M 2 Las                     | 7.   | 3 Yrs.                        |   |                               | January  | 12,                      | 1933                          | Maryland                          |
|                            | and w   |                | Usual Residence of Decedent  10a. State 10b. County   |                               | 10c. City  | , Town or Lo                  | ocation   |                               |  |                          |                               | 10d. Inside City Limits           |
|                            | Aaryl<br>f eho  | ō              | Maryland Caro   | lino                          | Den  | ton                           |   |                               |  |                          |                               | 1 ☐ Yes 2 ☐ No                    |
|                            | 28e-  | Director       | 10e. Street and Number  | LINE                          | Den  | COII                          | 10f. Zip Code                                   |                               |  | 10g. Citize              | en of What Co                 | ountry?                           |
|                            | with a or   |                | 9886 Mila Stree   | . 4                           |  |                               | 21629   |                               |  |                          |                               | es of Americ                      |
|                            | ne 23   | era            | 11. Marital Status  |                               | edent Ever in U.S  | S, 13.                        |   | ispanic Origi                 | in? (Specify Yes or No                             |                          | Race - Ame                    |                                   |
| 36                         | thin 72 hours atter deeth with the Maryland<br>e<br>en "naturel", or lierne 23e or 28e-f ehow<br>Medicel Exacilies must be rodiffed at  | by Funeral     | 1 Never Married 2 Mar<br>3 ₩ Widowed 4 Divorced   | If Yes G                      | 2 <b>⊠</b> No<br>ve  |                               | If Yes, specify Cuba<br>1 ☐ Yes 2 ☑ No          | Specify:                      | Puèrto Rican, etc.)                                |                          | Black, White<br>Specify: Cau  | te, etc.<br>Icasian               |
| Maryland 21215-0036        | 2 hou   |                |   | t's Education                 |  |                               | dent's Usual Occup                              |                               |  | 16b. Kind                | d of Business                 | /Industry                         |
| 5                          | C 9   | Completed      | (Specify only highe<br>Elementary/Secondary (0-12)  | st grade completed) College ( |  | (Give<br>life.                | kind of work done of<br>DO NOT use retired      | during most (<br>1)           | of working   | ;                        |                               |                                   |
| 2                          | M C T   | E              | 12  | Conege                        | 1-401 34)  | Ma                            | nager   |                               |  | F                        | Real Es                       | state                             |
| פ                          |   | Bec            | 17. Father's Name (First, Middle,   | Last)                         |  |                               |   | 18. Mother                    | 's Name (First, Middle                             | , Maiden S               | umame)                        |                                   |
| <u>a</u>                   |   | 10 E           | Dallas Neal   | L                             |  |                               |   | Mer                           | iam Wheatl   | .ey                      |                               |                                   |
| a                          | d 2 should<br>th and Men<br>7 is marke<br>traumatic   |                | 19a. Informant's Name/Relations   | hip (Type, Print)             |  | 19b. Maili                    | ng Address (Street                              | and Number                    | or Rural Route Numb                                | er, City or              | Town, State, .                | Zip Code)                         |
|                            | end 2   |                | Sylvia Trice  | Daugl                         | nter   | 9886                          | Mila St   | reet,                         | Denton, MD   | 21                       | 629                           |                                   |
| ore                        | of Heatt  |                | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation   | 2 Pamoual from                | 20b. PI  | lace of Dispo                 | osition (Name of matory or other place          | ea)                           | Date   | 20c. Loc                 | ation - City or               | Town, State                       |
| Ĕ                          | 0 0   |                | 4 Donation 5 Other (S   |                               | State  |                               | emetary   |                               | 5/12/2006  | Dento                    | n. Mar                        | vland                             |
| Baltimore,                 | permit. Pag<br>Department<br>Importent: I<br>eny Injury o   |                | 21. Signature of Funeral Service  | hill.                         |  | Mc                            | 2. Name and Addre                               | ss of Facility                | me. P.A.   |                          |                               |                                   |
|                            |   |                | 23a. Part1. Enter the disease lishock, or heart failure. Lish   | complications that            | caused the death   | . Do not en                   | 2 South Se<br>ter the mode of dyin              | econd<br>g, such as c         | Street, De ardiac or respiratory a                 | nton,                    | Maryl                         | Approximate<br>Interval Between   |
|                            | Physician   |                | Immediate Cause (Final  | only one cause on             | each line.   | Gu                            | 1- = 2  | 000                           | Tai  | and                      |                               | Onset and Death                   |
| 1                          | /Medical  |                | disease or condition<br>resulting in death)   | a. Due to                     | (or as a consequ   | rence ot):                    | , y   | V VC                          | was Jos  | <i>y</i>                 |                               | 7900                              |
|                            | Examiner  |                |   | 1                             | (or as a consequ   | sonco or,.                    | 20051   | ٥                             |  |                          |                               | Visel C                           |
|                            | Y   | er             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. Due to                     | (or as a consequ   | uence of):                    |   |                               |  |                          |                               | 500                               |
|                            | uted<br>d<br>ansit  | Examine        | Cause (Disease or injury  | <b>S</b> .                    |  |                               | Decuti  | Tuy                           | wien   |                          |                               | weeks                             |
| Ć                          | icate be executed<br>physicien and<br>s the burial-transit  | Exa            | resulting in death) Last  | Due to                        | (or as a consequ   | uence of):                    |   | 10                            |  |                          |                               |                                   |
| 8760,                      | ysicie<br>y bur   | dicai          |   | d                             |  |                               |   |                               |  |                          |                               |                                   |
| 9                          | g phy<br>as th  | ed             |   |                               |  |                               |   |                               |  |                          |                               |                                   |
| P.O. Box                   | To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Atter this certificate has been signed by the ellending physicien and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 1 Live                        | itcome of pregnal<br>birth 2 Petal<br>nant at time of de<br>nown | death 3[                      | □Ectopic pregnancy<br>□ Other (specify)         | ,                             |  | 23                       | 3d. Date of de<br>Month       | livery<br>Day Year                |
|                            | that<br>led by<br>deta  |                | Part II. Other significant conditi  | ons contributing to           | death but not resu   | ulting in the u               | underlying cause giv                            | en in Part I.                 | 23e. Did   | lobacco us               | e contribute t                | the cause of death?               |
| ds                         | uires tha<br>signed<br>Id be del  | q p            |   | <                             | 是以外  | - sx                          | mge. De   | will.                         | fact 10  | Yes 2                    | No 3□P                        | robably 4 Unknown                 |
| Ö                          | w require<br>been si<br>should I  | ete            |   | C                             | Day.A  | Cist                          | Form 5  | 2,00                          | 24a. Was   | an                       | 24h Were a                    | utopsy findings available         |
| Re                         | The lav   | Completed by   |   |                               | 70000  | a                             | 1900  | 173                           | auto   |                          | prior to death?               | completion of cause of            |
| ita                        | ien:<br>rtifica<br>stor, I  | 0              | 25. Was case referred to medica   | 1                             |  | /                             |   | 26. Place                     | of Death (Check only                               |                          |                               |                                   |
| <b>&gt;</b>                | ysic<br>iis ce<br>direc   | ToB            | examiner?   | Hospital: 1                   | npatient 2   | ER/Outpatie                   | nt 3 DOA Oth                                    | er: 4 🗆 Nur:                  | sing Home 5□Res                                    | idence 6                 | □Other (Spe                   | ecify)                            |
| 0                          | ig Ph<br>ter th<br>neral  |                | 27. Manney of Death   | 28a. Date                     | of Injury<br>oth, Day Year)                                      | 28b. Time o                   | of 28c. Injur<br>Wor                            | y at<br>k?                    | 28d. Describe                                      | how injury               | occurred                      |                                   |
| <u>Ö</u>                   | ath.  | atic           | Z _ Accident  | igation                       | ,,,  | ,,                            |   | Yes 2 □ N                     | lo   |                          |                               |                                   |
| Division of Vital Records, | of or Atta  | Certification: | 3 Surcide 6 Could 4 Homicide deterr   | nined 289. Plac               | e of Injury - At ho<br>ling, etc. (Specify                       | ome, farm, st                 | reet, factory, office                           |                               |  | Street and<br>wn, State) | Number or R                   | ural Route Number,                |
|                            | To the Hospital or Attending Physicien: The I within 24 hours elter death. To the Funerel Director: Atter this certificate ha completely tilled in by the funeral director, page  | Medical C      | 29a. Certifier 1 Certifyi (Check only 2 Medical   | Exeminer: On the              | e best of my kno-<br>basis of examinal                           | wledge, dea<br>tion and/or in | th occurred at the tir<br>nvestigation, in my o | ne, date and<br>pinion, death | I place, and due to the<br>h occurred at the time, | cause(s) a<br>date and p | and manner a<br>place, and du | s stated.<br>e to the cause(s)    |
| •                          | To the<br>Within<br>To the  | Me             | 29b. Signature and title of certific  | or tu                         | 11 W   | 10                            | 29c. Licens                                     | e number                      |  | 29d. Date                | signed (Mon                   | th, Day, Year)                    |
|                            | ٠   |                | 30. Name and address of person  | who completed cau             | ise of death (Item   | 23a) (Type                    | Print)  | int e                         | + 0.8  | Slave                    |                               | 10                                |
|                            |   |                | 31. Date filed (Month, Day, Year  | 10/ 1/2                       | Registrar's Signa  | ture                          | 1-100   | ). VV                         | 700  | -Nowa                    | 1 7                           |                                   |
|                            | Sta<br>Regist   | ate<br>rar     | JUL 182   | 157                           | registrar a Signa  | Ass                           | de  |                               |  |                          |                               |                                   |

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [

Certificate of Death 2. Dete of Deet 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** 2006 29. June 11:35 PM Bernard Chappell /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Riverdale Prince Georges Cresent Cities Center 8. Date of Birth (Month, Day Year) 4/8/1928 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. lest birthdey) 6. Sex 1FTM 2□ F Days **Funeral** Months Hours Richmond, VA 229-20-2604 Yrs. 78 Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland nent of Haatth and Mantal Hygiene.
Int: If Item 27 ie marked other than "natural", or Items 23a or 28a-1 ehow ary or other traumetic event, I'm Medical Examiner must be notified at 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 X Yes 2 No Aldelphi MD Prince Georges Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 20783 United States 9403 Higbee Court Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 257 No Specify: Specify: White ٥ 3 Widowed 4 Divorced Be Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 8th Roofer Private 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernice May Whitaker Wingfield Chappell Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Adelphi, MD 20783 9403 Higbee Court Aurora R. Chappell (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/2/2005 Brentwood, MD Department of Important: If any Injury or Fort Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service License Road Brentwood, MD 3401 Bladensburg 20722 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** Arterioscherotic Candiov Ascular Disease Immediate Cause (Finel disease or condition resulting in death) /Medical Faminer Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23h. Did tohacco use contribute to the cause of death? Part fi. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown enebral Intaration Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Candiomyopathy Encephalopathu 1 Yas 27 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 5 Pending 1 Aturel 1 Tes 2 🗆 No investigation death. Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) p 4 - Homicide To the Hospital of within 24 hours a To the Funeral Completaly filled 1 rtifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner steted. Medical 29a. Certifier (Check only 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 852 JUNE 30,2006 30. Name end address of persec who completed cause of deeth (Item 23e) (Type, Print) 4203 QUEENSBURY Rd MYSITSU: 1/2 MDY078/ RE 31. Dete filed (Month, Day, Year) State JUL 0 5 2006 Registrar

**DHMH 16 Rev 6/95** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8:21 A<sup>M</sup> JULY 2006 6 **JAMES** BRADLEY CAINE SR. /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner BERLIN ATLANTIC GENERAL HOSPITAL WORCESTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Davs Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Months Days **Funeral** 83 Yrs. JULY 14, DELAWARE Director 222-10-6533 Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND WORCESTER OCEAN CITY 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21842 10242 BENT CREEK ROAD USA Items 23e Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "naturel", or ite 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) REALTOR REAL ESTATE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be GROVER CLEVELAND CAINE HELEN ELIZABETH BRADLEY or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY LOU CAINE/WIFE 10242 BENT CREEK ROAD, OCEAN CITY, MARYLAND 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If eny injury or once. 7/10/06 BERLIN, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) SUNSET MEMORIAL PARK 21. Signature F neral Service Licen 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Caroliomy resulting in death) Due to (or as a consequent of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Stenosis The law requires that the death certificate be executed ortre that initiated events resulting in death) Last Due to (or as a consequence of): Disease Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year detached for in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rmed? 2 No 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.
To the Funeral Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 3□ DQA 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 29a. Certifier P Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

7/6/2006

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cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

tamnas

2006

|                            |   |                 | 1 - For<br>State<br>Registrar   | State of M  | larylan                       |                                 | irtment of F                            |   |   | iene2 () () ()                               | 22975   |
|----------------------------|---|-----------------|---|---|-------------------------------|---------------------------------|---|---|---|--|---|
|                            |   |                 | 1. Decedent's Name (First, Middle,  | Last)   |                               |                                 |   |   | 2. Date of Deat                           | h  | 3. Time of Death                                |
|                            | Physic<br>/Medi   |                 | Merle Coleman (   | Cain  |                               |                                 |   |   | Month                                     | Day Year 2004                                | 0122 A M  |
|                            | Examir  |                 | 4a. Facility Name (If not institution,  | give street and number  | )                             |                                 | 4b. City, Town, c                       | or Location of Death                        |   | 4c. County of Dea                            |   |
|                            |   |                 | Easton mem  | orial tos   | spr-la l                      | )                               | Eas                                     | Slon  |   | Talba  | 7-1-  |
|                            | Funeral   |                 | 5. Social Security Number 6   |   |                               | ast birthday)                   | If Under 1 Year<br>Months Days          | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birth<br>(Month, Day,          | Year) 9. Bir                                 | thplace (State or Foreign                       |
|                            | Director  |                 | 231-58-2106   | 1 □ M 2 Ø F   | 62                            | Yrs.                            | Widitis Days                            | TIOUIS WIII.                                | May 31 1                                  | 944 Mar                                      | land  |
|                            | and *   |                 | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City                     | , Town or Los                   | ration                                  |   |   |  | 10d. Inside City Limits                         |
|                            | Aarylan<br>  ehow   | ō               | Maryland Caroli   |   | _ ′                           |                                 | ALION                                   |   |   |  | 1 ☐ Yes 2X No                                   |
|                            | 28a-  | Director        | 10e. Street and Number  | Line  | Den                           | ton                             | 10f. Zip Code                           |   | 14  | og. Citizen of What Co                       |   |
|                            | with  | ă               | 11320 Butler Ro   | va d  |                               |                                 |   | .*  |   |  | •   |
|                            | within 72 hours after death with the Maryland ene.<br>then "netural", or Itema 23a or 28a-f ehow<br>the Muchical Exercities must be notilied at   | Funerai         | 11. Marital Status  | 12. Was Decedent  | Ever in U.S                   | S. 13. V                        | 21629                                   | dispanic Origin? (Sc                        | ecty Yes or No.                           | U.S.A.                                       |   |
| . (0                       | r Her   | F               | 1 ☐ Never Married 2 X Married   | Armed Forces  | ?                             | 1f                              |   | lispanic Origin? (Sp<br>an, Mexican, Puerto | Rican, etc.)                              | Black, Whit                                  | e, etc.   |
| 3 8                        | ors a   | Ā               | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:                                    |                               | 1                               | Yes 211 No                              | Specify:                                    |   | Specify: Wh                                  | ite   |
| 20-0                       | 72 hours<br>netural',   | Completed       | 15. Decedent's (Specify only highest  | Education   |                               | 16a. Deced                      | ent's Usual Occup                       | pation<br>during most of work               |   | 16b. Kind of Business                        | /Industry                                       |
| 7 2                        | thin  | p d             | Elementary/Secondary (0-12)   | College (1-4or  | 5+)                           | life. D                         | O NOT use retired                       | d)  | illig                                     |  |   |
|                            | ed w  | ပ္ပ             | 11  |   |                               | homem                           | aker                                    |   |   | own h  | iome  |
|                            | be filed<br>ital Hygid<br>od other  | Be              | 17. Father's Name (First, Middle, La  |   |                               |                                 |   | 18. Mother's Nam                            | e (First, Middle, N                       | faiden Sumame)                               |   |
| ∠ \Z                       | should be filed<br>and Mental Hygi<br>is marked other<br>sumatic event, II  | ၉               | Eldridge Glenn,   |   |                               |                                 |   |   | Coleman                                   |  |   |
| Maryland                   | 12 sh<br>h and<br>7 Is m  |                 | 19a. Informant's Name/Relationship  |   |                               |                                 |   |   |   | City or Town, State, a                       |   |
| <b>6</b> 1                 | is 1 and 2 should of Health and Men Item 27 is marke other treumatic  |                 | Rome W. Cain,   | Sr./ husba  |                               |                                 | Butler ]                                |   |   | ryland 216                                   |   |
| Baltimore,                 | Pages<br>nent of I<br>ont: If Its   |                 | 1 X Burial 2 ☐ Cremation 3  |   | '   .                         |                                 | ition (Name of<br>atory or other place  | I   |   | Oc. Location - City or                       |   |
| 章                          | it. Pi  | 1               | 4 □Donation 5 □Other (Spe<br>21. Signature, of Funeral Service Lig  |   | Hol                           |                                 | Cemeter                                 | y July                                      | 17 2006                                   | Harringto                                    | on, Delaware                                    |
| Ba                         | permit. Pages<br>Department of<br>Importent: If I'l<br>eny Injury or o  |                 | > April   | Fruk  |                               | FI<br>PO                        | egle and<br>Box 160                     | d Helfenb<br>Greensbo                       | ein Fune<br>ro, Mary                      | ral Home,<br>land 21639                      | PA  |
|                            |   |                 | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on                                    | mplications that cause<br>ly one cause on each I                  | d the death.                  | . Do not ente                   | r the mode of dyin                      | ng, such as cardiac                         | or respiratory arre                       | st,  | Approximate<br>Interval Between                 |
|                            | Physician   |                 | Immediate Cause (Final disease or condition   | LUI   | NG 1                          | + DENO                          | CARCINO                                 | MA  |   |  | Onset and Death                                 |
|                            | /Medical<br>Examiner  |                 | resulting in death)   | Due to (or as   | a consequ                     | ence of):                       |   |   |   |  |   |
|                            | LXammer   |                 | Sequentially list conditions,   | b. —  |                               |                                 |   |   |   |  |   |
| _                          | sit s   | Examiner        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as   | a consequ                     | ence of).                       |   |   |   |  |   |
|                            | and I-tran  | xan             | that initiated events<br>resulting in death) Last   | c<br>Due to (or as  | a consequi                    | ence of):                       |   |   |   |  |   |
| 68760,                     | cate be executed<br>physicien and<br>the burial-transit   |                 |   | 200 10 (0) 40   | u 00/1304u                    | onco or).                       |   |   |   |  |   |
| 587                        | phy<br>phy  | dicai           |   | d   |                               |                                 |   |   |   |  |   |
|                            | eath certifi<br>attending<br>for use as   | /We             | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome  | of pregnan                    | ncy                             |   |   |   | 22d Date of dal                              |   |
| B                          | atter<br>after<br>for u   | ciar            | in the past 12 months?  | 1 ☐ Live birth<br>4 ☐ Pregnant a                                  | 2 Fetal                       | death 3 □I                      | Ectopic pregnancy<br>Other (specify)    | ,   |   | 23d. Date of del<br>Month                    | Day Year  |
| P.O. Box                   | that the de<br>ed by the<br>detached  | ysi             | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9□ Unknown  |                               |                                 |   |   |   |  |   |
|                            | Attanding Physician: The law requires that the death certificath. r death. ector: After this certificete has been signed by the attending by the funeral director, page 2 should be detached for use as | by Physician/Me | Part II. Other significant conditions   | contributing to death b   | out not resul                 | lting in the un                 | derlying cause give                     | en in Part I.                               | 23e. Did toba                             | acco use contribute to                       | the cause of death?                             |
| rg                         | w requires t<br>been signe<br>should be   |                 |   |   |                               |                                 |   |   | 1 ☐ Yes                                   | 2 □ No 3 1 Pr                                | obably 4 Unknown                                |
| ္<br>ပို                   | law re<br>as bec<br>2 sho   | Completed       |   |   |                               |                                 |   |   | 24a. Was an                               | 24b. Were au                                 | topsy findings available                        |
| æ                          | The lavete has  | E O             |   | •   |                               |                                 |   |   | autopsy<br>perform                        | ed // death?                                 | topsy findings available completion of cause of |
| ta                         | ician: Th<br>certificete<br>ector, pag  | e e             | 25. Was case referred to medical  | 1   |                               |                                 |   | 26. Place of Deatl                          |   |  | 2 No  |
| >                          | ysici<br>is ce<br>direc   | ToB             | examiner?<br>1 ☐ Yes 2 ☑ No   | Hospital: 1 Inpatio   | ent 2 🗆 E                     | R/Outpatient                    | 3□ DOA Othe                             |   |   | ice 6 Other (Spec                            | erfy)   |
| 0                          | ng Pł   | Ë               | 27. Manner of Death 1 ☑Natural 5 ☐ Pending  | 28a. Date of Inju   | iry (                         | 28b. Time of<br>Injury          | 28c. Injun                              |   | 28d. Describe hov                         | ****   |   |
| , j                        | endir<br>sath.<br>or: Al  | atic            | 2 ☐ Accident investigat   | on  |                               | ,,                              |   | Yes 2 □ No                                  |   |  |   |
| Division of Vital Records, | r Att   | Certification;  | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine   | 289. Place of in  | jury - At hor<br>c. (Specify) | ne, farm, stre                  | et, factory, office                     |   | 28f. Location (Stre                       | et and Number or Ru<br>State)                | ral Route Number,                               |
| Q                          | ital o  | S               |   | 12  |                               |                                 |   |   |   |  |   |
|                            | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.  | edicai          | 29a. Certifier 1 Certifying (Check only one)  | Physician: To the best<br>aminer: On the basis o<br>and manner st | i examinatio                  | rledge, death<br>on and/or inve | occurred at the timestigation, in my of | ne, date and place,<br>pinion, death occurr | and due to the cau<br>ed at the time, dat | use(s) and manner as<br>e and place, and due | stated.<br>to the cause(s)                      |
|                            | Vithin<br>orther<br>omple   | Med             | 29b. Signature and title of certifier   | and mainer st   |                               |                                 | 29c. License                            | e number                                    | 29  | d. Date signed (Month                        | ), Day, Year)                                   |
|                            | ->-0  |                 | LARINE  | rothi   | 11.7                          | >                               | Do                                      | 059487                                      |   | 07/13/0                                      | 6   |
|                            |   |                 | 30. Name and address of person wh   | o completed cause of c  | death (Item :                 | 23a) (Type P                    |   |   |   |  |   |
|                            |   |                 | John Botsis,  | m.d. 219  |                               |                                 | ton St.                                 | , Easton.                                   | mi) 21                                    | 601  |   |
|                            | Sta   |                 | 31. Date filed (Month, Day, Year)   |   | ar's Signatu                  | A                               | 1                                       |   |   |  |   |
|                            | Registr   | ar              | 1111 1 /  | 2006  | A                             | 11 4                            | 3342                                    |   |   |  |   |

|                                |   | 4              | 1 - For<br>State<br>Registrar   | State of                                | Marylan                                      |                        | artmer<br>rtificat       |                     |                      | and M     | lental Hy                           | /giene<br>Reg. No.         | 200         | 6                   | 229                           | 977           |
|--------------------------------|---|----------------|---|---|--|------------------------|--------------------------|---------------------|----------------------|-----------|-------------------------------------|----------------------------|-------------|---------------------|-------------------------------|---------------|
|                                |   |                | 1. Decedent's Name (First, Middle, Las  | st)                                     |  |                        |                          |                     |                      |           | 2. Date of D<br>Month               | eath<br>Day                |             | ear ear             | 3. Time of                    | Death         |
|                                | Physici<br>/Medio   |                | John Walter Cor   | kell                                    |  |                        |                          |                     |                      |           | July                                | 10                         | 200         |                     | 3:00                          | A M           |
| 1                              | Examin  |                | 4a. Facility Name (If not institution, give   | street and numb                         | oer)   |                        | 4b. City,                | Town, or            | Location of          | of Death  |                                     |                            | County of I |                     |                               |               |
|                                |   |                | Talbot Hospice  |   |  |                        | 1                        | ston                |                      | O A Uso   |                                     |                            | Calbo       |                     |                               |               |
|                                | Funeral<br>Director   |                | 214-42-0102   | ex 7.                                   | Age (In yrs. I                               | Yrs.                   | Months                   | Days                | If Under:<br>Hours   | Min.      | 8. Date of B<br>(Month, D<br>July 1 | ay, Year)                  | 2 9         | Count               | ace (State o.<br>ry)<br>11and | r Foreign     |
|                                | and   |                | Usuel Residence of Decedent  10a. State 10b. County   |   | 10c. City                                    | y, Town or Lo          | ocation                  |                     |                      |           |                                     |                            |             | 10                  | d. Inside Cit                 | ty Limits     |
|                                | Marylan<br>f ehow   | 5              | Maryland Queen A  | nne                                     | Ra   | rclay                  |                          |                     |                      |           |                                     |                            |             |                     | 1 🗆 Yes                       | 2 <b>∑</b> No |
|                                | the 28a   | Director       | 10e. Street and Number  | inic                                    | Da   | rcray                  | 10f. Zij                 | p Code              |                      |           |                                     | 10g. Citiz                 | en of Wha   | t Count             | ry?                           |               |
|                                | 3a o  | <u>=</u>       | 1350 Barclay Ro   | ad                                      |  |                        | 216                      | 507                 |                      |           |                                     | USA                        |             |                     |                               |               |
|                                | deet  | Funeral        | 11. Marital Status  | 12. Was Decede                          |  | S. 13.                 | Was Dece                 | dent of Hi          | spanic Orig          | gin? (Spe | ecify Yes or N<br>Rican, etc.)      | 0- 1                       | 4. Race -   | America<br>White, e |                               |               |
| Baltimore, Maryland 21215-0036 | 72 hours after deeth with the Maryland<br>netural', or Itame 23a or 28a-1 ehow<br>Jisal Examiner wust be notified at                        |                | 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced  | 1 XYes 2<br>tf Yes, Give                | □No  |                        | 1 ☐ Yes                  |                     | Specify:             | , rueno   | nican, etc./                        |                            | Specify:    |                     | ite                           |               |
| Ö                              | 72 hours<br>"netural",  | ted            | 15. Decedent's Ed   | lucation                                |  | 16a. Dece              | dent's Usu               | al Occupa           | ation<br>furing most | e of work | 100                                 | 16b. Kin                   | d of Busin  | ess/Ind             | ustry                         |               |
| 215                            | within 7<br>ene.<br>than "r   | p d            | (Specify only highest gra<br>Elementary/Secondary (0-12)  | College (1-4                            | or 5+)                                       | life.                  | DO NOT u                 | ise retired         | )                    | O WOR     | ii ig                               |                            |             |                     |                               |               |
| 21                             | filed wi<br>Hygien<br>other th  | Completed by   | 09  |   |  | farm                   | er                       |                     |                      |           |                                     | bee                        |             |                     |                               |               |
| nd                             | d is b  | Be             | 17. Father's Name (First, Middle, Last)   |   |  |                        |                          |                     |                      |           | e (First, Middle                    |                            |             |                     |                               |               |
| <u>\Z</u>                      | should<br>nd Men<br>marka<br>umatic   | ၉              | Harry Corkell  19a. Informant's Name/Retationship (7)   | 5 0:0                                   |  | 401 14 18              |                          | 100                 |                      |           | Thomas                              |                            |             |                     |                               |               |
| Mai                            | 12 st<br>h and<br>7 is n<br>treun   |                |   | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |  |                        | -                        |                     |                      |           | al Route Numi<br>rclay,             |                            |             |                     |                               |               |
| e,                             | ges 1 end 2 t of Heelth If Item 27 or other tre   |                | Joyce R. Corkell/ 20a. Method of Disposition  | wile                                    | 20b, P                                       | lace of Dispo          |                          |                     |                      |           | Date                                |                            | ation - Cit |                     |                               |               |
| 2                              | 0 0   |                | 1 ☑Bunal 2 ☐ Cremation 3 ☐  |   | ale  |                        |                          |                     | 1                    | - 7/      | 11.100                              |                            |             |                     |                               | 1             |
| Ē                              |   |                | 4 Donation 5 Other (Specify 21. Signature of Faneral Service Licen  |   | we   |                        |                          |                     | s of Facilit         |           | 14/06                               | Burrs                      | SVILL       | e, r                | iaryla                        | nd            |
| Ba                             | permit. Departr Importe any Inji  |                | Items C   | Kl.                                     | 6  | F                      | leeg.                    | le an               | id Hel               | Lfenl     | oein Fu<br>oro, Ma                  | ineral                     | Hom         | e, E                | PA                            |               |
|                                | _   |                | 23a. Part1. Enter the disease, or compshock, or heart failure. List only                                    | olications that cau                     | ised the death                               |                        |                          |                     |                      |           |                                     |                            | 14 21       |                     | Approximate<br>Interval Bety  | 3             |
| - 9                            | Physician   |                | Immediate Cause (Final disease or condition   | A/A                                     | 1 PM   | 201 (                  | 001                      | (01                 | b                    | Ca        | nor                                 |                            |             |                     | Onset and E                   | Death         |
|                                | /Medical  |                | resulting in death)   | Due to (or                              | as a consequ                                 | uence of):             | M                        | <u>u</u>            | 20/                  | <u></u>   |                                     |                            | <u>.</u>    |                     |                               | 05.           |
|                                | Examiner  |                | Sequentially list conditions  | b                                       |  |                        | -                        |                     | 1                    |           |                                     |                            |             |                     |                               |               |
|                                | p #   | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or                              | as a consequ                                 | uence of):             |                          |                     |                      |           |                                     |                            |             |                     |                               |               |
|                                | ecute<br>and<br>-trans  | Examiner       | that initiated events resulting in death) Last  | C                                       |  | 12002 of);             |                          |                     |                      |           |                                     |                            |             | _                   |                               |               |
| 8760,                          | ate be executed<br>hysicien and<br>the burial-transit   | <u>E</u>       | 1   | Due to (or                              | as a consequ                                 | derice or):            |                          |                     |                      |           |                                     |                            |             |                     |                               |               |
| 87                             | the py  | dical          | •   | d                                       |  |                        |                          |                     |                      |           |                                     |                            |             |                     |                               |               |
| 9 x                            | aath certitic<br>ettending p<br>for use as  | Physician/Me   | IF FEMALE:  | 23c. tf yes, outco                      | me of pregna                                 | ncy                    |                          |                     |                      |           |                                     | 2                          | 3d. Date o  | f deliver           | v                             |               |
| Вох                            | etter<br>of for L   | clar           | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No  |   | h 2 ☐ Fetel<br>nt at time of de              |                        | ]Ectopic p<br>☐ Other (s |                     |                      |           |                                     | -                          | Month       |                     | •                             | 'ear          |
| P.O.                           | that the do   | hys            | 9 Unknown   | 9□ Unknow                               | m  |                        |                          |                     |                      |           |                                     |                            | _           |                     |                               |               |
|                                | The law requires that the death certific site has been signed by the ettending p cage 2 should be detached for use as                       | by P           | Part It. Other significant conditions of  | ontributing to dear                     | th but not resu                              | ulting in the u        | nderlying                | cause give          | en in Part I.        |           | 23e. Did                            | tobacco us                 | e contribu  | te to the           | cause of d                    | eath?         |
| of Vital Records,              | v require<br>been sig<br>should b   | ed tr          |   |   |  |                        |                          |                     |                      |           | 1 🗖                                 | Yes 2                      | ]No 3[      | Proba               | bly 4 □U                      | Inknown       |
| တ္တ                            | aw requis been 2 shoult   | plet           |   |   |  |                        |                          |                     |                      |           | 24a. Wa                             |                            |             |                     | sy findings a                 |               |
| Ä                              | The lay   | Completed      |   |   |  |                        |                          |                     | ****                 |           | auto<br>perf                        | ormed2                     | deat        | h?<br>Yes 2         | pletion of ca<br>2□ No        | iuse oi       |
| ita                            | ysician: Th<br>is certificete<br>director, pag  | Bec            | 25. Was case referred to medicat examiner?  |   |  |                        |                          |                     | 26. Place            | of Death  | (Check only                         |                            |             |                     |                               |               |
| <u>&gt;</u>                    | d is  | ၉              | 1  Yes 2  1  10   |   | patient 2                                    | ER/Outpatie            |                          |                     |                      | rsing Ho  | me 5 Res                            | idence 6                   | Other (     | Specify)            | Hospic                        | ethouse       |
| D C                            | ng P  |                | 27. Manner of Death 1 □ Matural 5 □ Pending   | 28a. Date of<br>(Month,                 | Injury<br>Day Year)                          | 28b. Time of<br>tnjury |                          | 28c. tnjury<br>Work |                      | 1         | 28d. Describe                       | how injury                 | occurred    |                     |                               |               |
| sio                            | death.<br>death.<br>ctor: A<br>y the fu   | cat            | 2 Accident investigation 3 Suicide 6 Could not be   |   |  |                        | М                        |                     | Yes 2 🗍 1            |           |                                     |                            |             |                     |                               |               |
| Division                       | efter of Direction by   | Certification: | 4 Homicide determined   | 266. Ptace of                           | f tnjury - At ho<br>j, etc. <i>(Specif</i> y | me, farm, st           | reet, factor             | y, office           |                      |           | 28f. Location<br>City or To         | (Street and<br>own, State) | Number      | or Rural            | Route Numi                    | ⊅e <i>r</i> , |
|                                | ospital<br>hours e<br>uners! I  |                | 29a. Certifier 1 Certifying Ph  | vsician: To the h                       | est of my kno                                | wledge deat            | h occurren               | at the tim          | e, date an           | d place   | and due to the                      | Cause/s)                   | and mane    | ar pe eta           | ited                          |               |
|                                | To the Hospital or Attending Ph<br>within 24 hours efter death.<br>To the Funeral Director: After th<br>completely filled in by the funeral | Medical        | (Check only 2 Medicat Exam  | niner: On the bas<br>and manne          | is of examinat                               | tion and/or in         | vestigation              | n, in my of         | oinion, dea          | th occurr | ed at the time                      | , date and                 | place, and  | due to              | the cause(s)                  | ļ             |
|                                | To the H<br>within 24<br>To the Fi<br>complete  | Me             | 29b. Signature and title of certifier   |   |  |                        | 29                       | c. License          | number               |           |                                     | 29d. Date                  | signed (A   | tonth, D            | ay, Year)                     |               |
|                                | 0   |                | > Made  | MM                                      |  |                        |                          | 13                  | 788                  | 7         |                                     | 7                          | /10         | 100                 | 0                             |               |
|                                |   |                | 30. Name and address of person who  | eompleted cause                         |  |                        |                          | - 1                 | , 55                 |           |                                     | (                          | 1           |                     |                               |               |
|                                |   |                | David H. Smith 2  | 9466 Pin                                |  |                        | 5; Ea                    | ston                | , MD                 | 2160      | )1                                  |                            |             |                     |                               |               |
|                                | Sta<br>Registi  |                | 31. Date filed (Month Day, Year)  | 6 32 Rec                                | gistrar's Signa                              |                        | solf )                   |                     |                      |           |                                     |                            |             |                     |                               |               |

|                |  |                   | For State   | State of Marylar  | •  | nt of Health and te of Death                             |  | -2000                                  | 22978  |
|----------------|--|-------------------|---|---|--|--|--|--|--|
|                | <u> 5.</u>   | 参                 | Registrar  1. Decedent's Name (First, Middle, Las.  | )   | Certifica                                | le oi Dealii   | 2. Date of Death                           |  | 3. Time of Death                                   |
| 5              | Physici<br>/Medio<br>Examir  | al                | 4a. Facility Name (If not institution, give   | Dunn (  | OCK 4b. Cin                              | y, Town, or Location of Deat                             | July                                       | Day Year  Ac. County of Deal           | 1:50p M  |
|                | ×  | i ei              | Chesapea<br>5. Social Security Number 6. Se   | Ke Woods  | 0  | ambride<br>er 1 Year   If Under 24 Hrs                   | a e  |  | hester   |
|                | Funeral<br>Director  |                   | 577-16-8065   | M 210 F 93  | Yrs. Months                              |  | 8. Date of Birth<br>(Month, Day,<br>May 13 | 1/1/1 4                                | thplace (State or Foreign<br>ountry)               |
|                | tryland<br>show  | _                 | Usual Residence of Decedent  10a. Slale  10b. County  | 10c. Ci   | ty, Town or Location                     | 1  |  | <u>/</u>                               | 10d. Inside City Limits                            |
|                | the Ma<br>28a-f  | recto             | MD Dove 10e. Street and Number 4629-  | rester larrisville Ro   | WOOLF (                                  | o Code   | 10   | og. Cilizen of What Co                 | 1 Tyes 2 MNo                                       |
|                | th with<br>23a or  | al DI             | P. O. BOX 123   | )   | 340                                      | 21677  |  | U5 F                                   | 7  |
| "              | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or itema 23e or 28e-f ahow<br>ha Medical Examinar must be notified at | Funeral Director  | 11. Marital Status 1 ☑ Never Married 2 ☐ Married  | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 2 ☑ No       | If Yes, sp                               | edent of Hispanic Origin? (Secrify Cuban, Mexican, Puerl | pecify Yes or No-<br>to Rican, etc.)       | 14. Race - Ame<br>Black, Whit          |  |
| 215-0036       | 72 hours a<br>"natural", o   | ed by             | 3  Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:                                      | 1 ☐ Yes                                  |  | 1  | Specify: B1                            | ack  |
| 215            | thin 72<br>e.<br>an "na<br>Medic   | Completed         | (Specify only highest grad  | College (1-4or 5+)  | (Give kind of w                          | vork done during most of wor<br>use retired)             | rking                                      | ob. Kind of Business                   | . /  |
| d 21           | filed with<br>Hygiene.<br>other the  |                   | 17. Father's Name (First, Middle, Last)   |   | Domes                                    | Tic Won.   | Ker S<br>ne (First, Middle, M              |  | se's home  |
| Maryland       | Mental<br>Mental<br>arked o  | To Be             | Charles   | Dunn  | ock                                      | Ann  | ie Al                                      | rmstron                                | 19   |
| Mar            |  |                   | 19a. Informant's Name/Relationship (T   | /pe, Print)   | 19b. Mailing Addres                      | ss (Street and Number or Ru<br>125 – Woolf               | iral Route Number,                         | City or Town, State, 2                 | Zie (sode)   |
| ore,           | Pages 1 and<br>lent of Health<br>nt: If Item 27<br>iry or other tr   | 19                | 20a. Method of Disposition 1 Burial 2 Cremation 3   | Removal from State  | Place of Disposition (National Comments) | ame of other place)                                      | Date 2                                     | Oc. Location - City or                 | Town, Slate  |
| altimor        | artmartmorts orta  |                   | 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service License                                   | SA  | 1: thville C                             | e Metery   //  | 3/06 to                                    | aylors Isla                            | arud, MD.  |
| ä              | Per Per Per Per Per Per Per Per Per Per  |                   | Janelle C   | . Henry   | Henry                                    | and Address of facility I Fun eral Washington            | St. Can                                    | ibridge, 1                             | ND.2/6/3   |
|                | Physician  |                   | 23a. Pant. Enter the disease, or comp<br>shock, or heart failure. List only o<br>Immediate Cause (Final     | 1 Cause on each line.   | n. Do not enter the mo                   | ode of dying, such as cardiad                            | or respiratory arre                        | st,                                    | Approximate<br>Interval Between<br>Onset and Death |
|                | /Medical<br>Examiner   |                   | disease or condition resulting in death)  | Due to (or as a consec  | juence of):                              | , ,  |  |  | 104625   |
| ٠              | **************************************   | ner               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consec  |  | rmalities  |  |  | 1 week   |
|                | be executed<br>sician end<br>burial-transit  | Examine           |   | c   | uence of):                               |  |  |  |  |
| 8760           | ate be ex<br>hysician<br>the burial  |                   | (   | d   |  |  |  |  |  |
| Box 6          | eath certific<br>attending pl  | n/Mec             | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of pregna                                      |  |  |  | 23d. Date of del                       | ivery  |
| P.O. B         | the<br>thed  | Physiclan/Medical | in the past 12 months? 1 Yes 2 100 9 Unknown  | 1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of c<br>9 ☐ Unknown |  |  |  | Month                                  | Day Year   |
|                | res that thighed by  | Ď                 | Part II. Other significant conditions co  | ntributing to death bul not res                                     | ulting in the underlying                 | cause given in Part I.                                   |  | acco use contribute to                 |  |
| cord           | w requir<br>been si<br>should  | leted             |   |   |  |  | 24a. Was an                                |  | obably 4 Unknown utopsy findings available         |
| Vital Records, |  | Completed         |   |   |  |  | autopsy<br>perform<br>1 Yes 2              | prior to death?                        | completion of cause of                             |
| Vita           | S 80   | o Be              | 25. Was case referred to medical examiner?  1 Yes 2 No  | Hospital:   | IEB/Outcomes action                      | 100  | ath (Check only one                        |  |  |
| n of           | ling<br>After<br>une   | -                 | 27. Manner of Death  1- Natural 5 Pending   | 28a. Date of Injury (Month, Day Year)                               | 28b. Time of Injury                      | 28c. Injury at<br>Work?                                  | 28d. Describe hov                          | nce 6 Other (Spec<br>w injury occurred | city)  |
| Division       | Attender death   | Certification:    | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined                                     | 28e. Place of Injury · At h<br>building, etc. (Specia               | ome, farm, street, factor                | 1 Yes 2 No   | 28f. Location (Stro<br>City or Town,       | eet and Number or Au<br>State)         | ural Route Number,                                 |
| Ö              | To the Hospital or A within 24 hours after to the Funeral Direc completely filled in by  |                   |   |   |  | d at the time, date and place                            |  |  | stated   |
|                | the Ho<br>nin 24 h<br>tha Fur<br>npletely  | Medical           | (Check only 2 Medical Exam  | ner; On the basis of examina<br>and manner stated.                  | ation and/or investigation               | n, in my opinion, death occu                             | irred at the time, da                      | te and place, and due                  | to the cause(s)                                    |
|                | To To  | <                 | 29b. Signature and title of certifier   | in obv  | 29                                       | H0 599 73  | 29   | d. Date signed (Monti                  | 11, UBY, YBAI)                                     |
| •              |  |                   | 30. Name and address of person who c  | ompleted cause of death (Iter  2006  32. Resistrar's Signe          | n 23a) (Type, Print)  Brando             | St Camb  | vidae                                      | no                                     |  |
| F              | Sta  | -                 | 31. Date filed (Month, Day, Year)   | 2006 32. Registrar's Signa  | ature K Acce                             | Si Camo  | inge.                                      |  |  |
|                | Regist   | ar                | JUL - V   | - Marie   | No. Inches                               |  |  |  |  |

|             |  |                 | 1 - For<br>State<br>Registrar  | State of Marylan  |                                 | artment of H<br>tificate of I                 |  |   | iene) () ()<br>ag. No.                      | 22979   |
|-------------|--|-----------------|--|---|---------------------------------|---|--|---|---|---|
|             | -  |                 | 1. Decedent's Name (First, Middle, Last)   |   |                                 |   |  | 2. Date of Death                            | h<br>Day Year                               | 3. Time of Death                                  |
|             | Physicia<br>/Medic   |                 | Darlene Davi   | es  |                                 |   |  | July 7.                                     |   | 3:30 P M  |
|             | Examin   |                 | 4a. Facility Name (If not institution, give st   | treet and number)   |                                 | 4b. City, Town, or                            | Location of Death                        | 1   | 4c. County of De                            | ath   |
|             |  |                 | Southern Maryland  |   |                                 |   | inton                                    |   | Prince G                                    |   |
|             | Funeral<br>Director  |                 | 5. Social Security Number 6. Sex 104 - 66 - 7264   | 7. Age (In yrs. I   | ast birthday)<br>Yrs.           | If Under 1 Year<br>Months Days                | Hours Min.                               | 8. Date of Birth (Month, Day, July 17,      | 9. B<br>1948 Ker                            | irthplace (State or Foreign<br>Country)<br>TTUCKY |
|             | D  |                 | Usual Residence of Decedent  |   |                                 |   |  |   |   |   |
|             | how  |                 | 10a. State 10b. County   | 10c. City   | , Town or Lo                    | cation  |  |   |   | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No            |
|             | e Ma   | 5               | Maryland Charles   |   | Waldo                           | rf  |  |   |   | 1 162 20 NO                                       |
|             | or 20  | Dire            | 10e. Street and Number   |   |                                 | 10f. Zip Code                                 |  | 11  | 0g. Citizen of What (                       | Country?  |
|             | ath w  | ā               | 2512 Regal Place   |   |                                 |   | 0601                                     |   | USA   |   |
|             | filed within 72 hours after death with the Maryland<br>Hygiene.<br>kher than "naturel", or Items 23e or 28e-f show<br>kher than "naturel", or Items 23e or 28e-f show<br>ent, it is Medical Exacuter must be notified at | Funeral Directo | THE THE STATE OF T | 2. Was Decedent Ever in U. Armed Forces?  | S. 13. \                        | Was Decedent of H<br>f Yes, specify Cuba      | ispanic Origin? (S<br>in, Mexican, Puert | pecify Yes or No-<br>o Rican, etc.)         | 14. Race - An<br>Black, Wh                  | nencan Indian,<br>nite, etc.                      |
| 30          | rs aft   | by F            | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced   | 1 ☐ Yes 2 🔁 No<br>If Yes, Give<br>Year or Dates:                                    |                                 | I ☐ Yes 2 🛭 No                                | Specify:                                 |   | Specify:                                    | White   |
| 215-0036    | hour ture  | edt             | 15. Decedent's Educ  |   | 16a. Deced                      | ient's Usual Occupa                           | ation                                    |   | 16b, Kind of Busines                        | s/Industry  |
| Ċ           | in 72  | Completed       | (Specify only highest grade  | completed)  | (Give<br>life. l                | kind of work done o<br>DO NOT use retired     | during most of wor<br>l)                 | king  |   | ,   |
| 7           | iene.  | E O             | Elementary/Secondary (0-12)  | College (1-4or 5+)<br>2   | Accou                           | inting An                                     | alvst                                    |   | FBI   |   |
| 0           | tilec<br>Hyg<br>othe   | a               | 17. Father's Name (First, Middle, Last)  |   |                                 | -   |  | ne (First, Middle, M                        | Maiden Sumame)                              |   |
| <u>a</u>    | fental<br>rked o   | To B            | George McCowan   |   |                                 |   | Imo                                      | gene Smit                                   | ch  |   |
| Maryland    | s 1 and 2 should<br>f Health and Men<br>item 27 is marke<br>other treumatic  |                 | 19a. Informant's Name/Relationship (Typ  | oe, Print)  | 19b. Mailin                     | g Address (Street                             | and Number or Ru                         | ral Route Number,                           | City or Town, State                         | Zip Code)   |
|             | and 2<br>ealth<br>n 27 I   |                 | Michele Davies - D   |   | Committee Committee             | Regal P                                       | lace, Wa                                 | The second second second                    |   |   |
| Ze          | 00   |                 | 20a. Method of Disposition 1 Burial 2 Cremation 3 Re   |   | lace of Dispo<br>emetery, crer  | sition (Name of<br>natory or other place      |  |   | 20c. Location - City of                     |   |
| altimore,   | Pages<br>nent of I   |                 | '4 □Donation 3 □ Other (Specify)   | Hun   | tt Cre                          | ematory                                       | 7-11                                     | -2006 W                                     | Naldorf, M                                  | ID  |
| Balt        | permit. Pag<br>Department<br>Importent: I<br>eny injury o  |                 | 21. Signature of Pureral Service Licent  | Jelisen   |                                 | Name and Address                              |  |   | ld Washing<br>, Waldorf                     | ton Road<br>, MD 20604                            |
| Γ           |  |                 | 23a. Part1. Enjer the disease, or complice shock, or heart failure. List only on   | cations that caused the death   |                                 |   |  | or respiratory arre                         | est,  | Approximate<br>Interval Between                   |
|             | Physician  |                 | Immediate Cause (Final disease or condition  | A   | rute                            | My con  | mind                                     | hopara                                      | ron   | Onset and Death                                   |
|             | /Medical   |                 | resulting in death)  | Due to (or as a consequ   | uence of):                      | 7 100 1                                       | T.                                       |   |   |   |
|             | Examiner   |                 | Sequentially list conditions b.  | C   | NON.                            | gy or   | 1 my                                     | DIV SAT                                     | $\varepsilon$                               | 96A1  |
|             | D #  | Iner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Due to (or as a consequ   | uence of):                      | 0   | 0  |   |   | 0   |
|             | and<br>trans   | Examiner        | that initiated events c. resulting in death) Last  | Due to (or as a consequ   | ionco of):                      |   |  |   |   |   |
| 20,         | be ex<br>cian<br>ourial  |                 |  | Due to (or as a consequ   | derice or).                     |   |  |   |   |   |
| 28760       | icate be executed<br>physician and<br>s the burial-transit   | edical          | d.   |   |                                 |   |  |   |   |   |
| _           |  | lan/Me          | IF FEMALE: 23  | 3c. If yes, outcome of pregna   | ncv                             | _   |  |   | 23d. Date of d                              | alivany   |
| Box         | atten<br>for u   | Iclan           | in the past 12 Inonths?  | 1 ☐ Live birth 2 ☐ Fetal<br>4 ☐ Pregnant at time of d                               | death 3                         | Ectopic pregnancy Other (specify)             |  |   | Month                                       | Day Year  |
| o.          | the d<br>y the<br>iched  | Physi           | 1 Yes 2 No<br>9 Unknown  | 9□ Unknown  |                                 |   |  |   |   |   |
| ٦           | The law requires that the death certi<br>tte has been signed by the attending<br>bage 2 should be detached for use a   | by Pr           | Part II. Other significant conditions con-   | tributing to death but not res  | alting in the u                 | nderlying cause give                          | en in Part I.                            | 23e. Did tob                                | acco use contribute                         | to the cause of death?                            |
| g           | quires<br>n sign   |                 | DIAGE  | Tes velle   | $\mathcal{U}$                   |   |  | 1 □ Ye                                      | ıs 21 <b>2N</b> 0 3⊡I                       | Probably 4 Unknown                                |
| Records,    | w require<br>s been si<br>should b   | lete            |  |   |                                 |   |  | 24a. Was a                                  |   | autopsy findings available                        |
| Re          | The lav  | Completed       | -  |   |                                 |   |  | autops                                      | nped? death?                                | o completion of cause of<br>es 2 No               |
| Vital       |  | a               | 25. Was case referred to medical   |   |                                 |   | 26. Place of Dea                         | 1 ☐ Yes 2<br>ith (Check only on             |   |   |
|             | 10 77  | OB              | examiner?  | ospital: 1 Inpatient 2  | ER/Outpatier                    | t 3 DOA Oth                                   | 0.01                                     |   | ince 6 Other (Sp                            | pecify)   |
| 0           | ding Phy<br>h.<br>After this<br>funeral c  | n: T            | 27. Manner of Ceath  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury          | 28c. Injun<br>Worl                            | y at<br>k?                               | 28d. Describe ho                            | w injury occurred                           |   |
| 0           | tending<br>leath.<br>lor: After<br>the funer   | atlo            | 1 Natural 5 Pending 2 Accident investigation   | (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,   | ,,                              |   | Yes 2 □ No                               |   |   |   |
| Division of | of or Attendated after death Director:   | Certification:  | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At he building, etc. (Specify                                |                                 | eet, factory, office                          |  | 28f. Location (St<br>City or Town           | reet and Number or i<br>, State)            | Rural Route Number,                               |
|             | To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by   | edical C        | 29a. Certifier Check only one)  1 Certifying Phys 2 Medical Examin   | sician: To the best of my kno<br>ner: On the basis of examina<br>and manner stated. | wledge, deatl<br>tion and/or in | n occurred at the tin<br>vestigation, in my o | ne, date and place<br>pinion, death occu | , and due to the ca<br>rred at the time, da | ause(s) and manner<br>ate and place, and di | as stated.<br>ue to the cause(s)                  |
|             | rethin To the complete   | Me              | 29b. Signature and title of certifier  |   |                                 | 29c. Licens                                   | e number                                 | 25  | 9d. Date sighed (Mg)                        | nth, Day, Year)                                   |
|             | ->-0   |                 | 1  |   |                                 | $\wedge$                                      | 4543                                     | 7   | 7/7/6                                       | 6   |
| 1           |  |                 | 30. Name and address of person who co  | mpleted cause of death (Item  | 23a) (Type,                     | Print)  | 1  | 1-11.2                                      |   | 1,44,1  |
| 1           | B12  |                 | track Thisky   | avm //  | 201 0                           | 1/1/1/1/V                                     | Too de                                   | 1 "10)                                      | 11.69                                       | The About   |
|             | Sta<br>Registr   |                 | 31. Date filed (Month, Day, Year)  | 32. Pigistrar's Signa   | ture /                          | berte   |  |   |   | 20149   |

|  | 1 - For State Registrar  1. Decedent's Name (First, Middle, Last)   | State of Marylan   | •                                |  | of Health a<br>of Death                              |  | Reg. No.2                           | 006 22980<br>3. Time of Death   |
|--|---|--|----------------------------------|--|--|--|-------------------------------------|---|
| Physician<br>/Medical<br>Examiner  |   |  | ant                              | 4b. City, To                             | wn, or Location of                                   | July   | Day<br>6                            | Year 2006 12:00 PM  |
| Funeral<br>Director  | 304-20-7477   | 7. Age (In yrs.  | last birthday)<br>Yrs.           | Elkt                                     |  | 24 Hrs. 8. Date of (Month, 10/2                | Birth<br>Day, Year)<br>28/26        | 9. Birthplace (State or Foreign<br>Country)<br>Indianapolis,                              |
| death with the Maryland me 23e or 28e-f show rimust te incitited at neral Director   | Usual Residence of Decedent  10a. State 10b. County  Maryland Cecil   |  | y, Town or Lo<br>Elkton          | cation                                   |  |  |                                     | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No  |
| filer death with the Mar<br>riteme 23e or 28e-1 si<br>Lier must be notified<br>Funeral Director  | 10e. Street and Number 79 Dant Lane   |  |                                  | 10f. Zip Co                              | 921  |  |                                     | of What Country?<br>ited States   |
| or the same of the | 11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced   | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 2 ☒ No<br>If Yes, Give<br>Year or Dates:  | 1                                | Was Deceden<br>f Yes, specify<br>I□Yes 2 |  | gin? (Specify Yes or<br>i, Puerto Rican, etc.) |                                     | Race - American Indian,<br>Black, White, etc.<br>Incify: White                            |
| 21215- 1 within 72 jene. r than 'nation made in Madic  | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   |  | (Give                            |  | occupation<br>done during mos<br>retired)<br>d Nurse | t of working                                   |                                     | f Business/Industry   |
| be file doth doth avent  | 17. Father's Name (First, Middle, Last) Ambrose Gasper  |  |                                  |  | Gla  | n's Name <i>(First, Midd</i><br>adys Webb      |                                     | _   |
|  | 19a. Informant's Name/Relationship (Ty, Phillip L. Dant (  20a. Method of Disposition   | son)   |                                  | ant La                                   | ne, Elkt   | or or Rural Route Nur<br>Con, Maryl<br>Date    | and 21                              | wn, State, Zip Code) 921 on - City or Town, State   |
| Baltimore, permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.  | 1 M Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License  | A A  | ll Sai:                          | nts Ce                                   | metery   | 07/10/06<br>Funerals,                          | P.A.                                | ngton, Delaware Maryland 21921  |
| icate be executed physicien and she burial-transit she burial-transit edical Examiner  | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | e cause on each line.  ALZIFEI  Due to (or as a conseq   | M E i<br>uence of):              |  |  |  | / arrest,                           | Approximate Interval Between Onset and Death  |
| Box 6 Bath certif attending for use a  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown   | 3c. If yes, outcome of pregna<br>1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of d<br>9 ☐ Unknown   | I death 3                        | Ectopic pregr<br>Other (speci            |  |  |                                     | Date of delivery<br>Month Day Year  |
| S, es if   | Part II. Other significant conditions con   | tributing to death but not res   | ulting in the ur                 | nderlying caus                           | se given in Part I.                                  | 16   | Yes 2 No                            |   |
| Re(he lay e has age 2  | 25. Was case referred to medical examiner?  |  | 1077                             |  | 26. Place  | pe   | rformed?<br>2 No                    | b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ✓ No |
| On of ding Phys After this funeral dis   | 27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined   | ospital: 1 Inpatient 2 Impatie | 28b. Time of Injury              | 28c.                                     | Injury at Work?                                      | No 28f. Location                               | e how injury occ                    |   |
| Division  To the Hospital or Attention within 24 hours efter dealing to the Funeral Director: completely filled in by the Medical Certifical   | 29a. Certifier 1 Certifying Phys<br>(Check only 2 Medical Examinone)  | ician: To the best of my kno<br>ler: On the basis of examina<br>and manner stated.   | wledge, death<br>tion and/or inv | occurred at trestigation, in             | he time, date an<br>my opinion, dea                  | d place, and due to the                        | ne cause(s) and<br>e, date and plac | manner as stated.<br>ee, and due to the cause(s)  |
| To the within To the comple  | 29b. Signature and title of certifier  Thurbur E.  30. Name and address of person who co  215 North Street  | Moderny  | M ()                             |  | chor E   | 223  |                                     | ned (Month, Day, Year) 7, 2006  |
| g<br>State   | 30. Name and address of person who do 215 NC1 th 5 th 6 th 1 th 1 th 1 th 1 th 1 th 1 th 1  | 32. Registrar's Signa  | EIKT                             | 611 J                                    | VID "  | 7192   | г                                   |   |

DHMH 17 Rev 1/2001

AGNES LOUISE DANT

| 06-04691  |                | Please Type or Print in  |   | lugione              |                                       |  |
|---|----------------|--|---|----------------------|---------------------------------------|--|
| Amended#  | 20             | State of Maryland / Department of State of Maryland / Department of Certificate of Maryland / Certificate of Maryland / Certificate of Maryland / Certificate of Maryland / Certificate of Maryland / Certificate of Maryland  |   |                      | 000                                   | 5 0000   |
| Physicia  |                | Registrar TCHD 07/14/06, srr<br>1 Decedent's Name (First, Middle, Last)  |   | 2. Date of Deat      |                                       | 3. Time of Death                               |
| Medical Examir  | ıer            | Camillo Dejesus  |   | July 4, 200          |                                       | 1059 hrs                                       |
| Jana  |                | 4a. Facility Name (if not institution, give street and number) 32910 Cypress Road  | 4b. City, Town, or Location of Dea<br>Millington                        | ath                  | 4c County of Death<br>Kent            |  |
| Funeral   |                | Social Security Number 6. Sex 7. Age (In yrs last birthday)  | If Under 1 Year If Under 24H  | lrs 8. Date of Bir   |                                       | thplace (State or                              |
| Director  | ł              | 582-28-6641 1 <b>X</b> M 2□F 76 Y  | Months Days Hours M   | 12-14-               | 1929 Foreig                           | Puerto<br>Rico                                 |
| s.  |                | Usual Residence of Decedent  |   |                      |                                       | 10d Inside City Limits                         |
| low any.  |                |  |   |                      |                                       | 1 Yes 2 X No                                   |
| aryland<br>8a-f sh  | Director       | Maryland   Kent   Millingt   | On<br>10f. Zip Code   | 10                   | 0g. Citizen of What Cou               |  |
| the M<br>a or 2   | ä              | 32910 Cypress Road   | 21651   |                      | USA                                   |  |
| h with  | Funeral        | 11. Marital Status 12. Was Decedent Ever in U.S 13. V  | Vas Decedent of Hispanic Origin? (<br>Yes, specify Cuban, Mexican, Puer |                      |                                       | can Indian, Black,                             |
| er deat   | Ӹ              | 1 Yes 2 No   | Yes 2 No specify Pue  |                      |                                       | to Rican                                       |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. | à              | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent  | ent's Usual Occupation (Give kind o                                     | f work done          | 16b. Kind of Business/I               |  |
| 5<br>72 hou<br>m "ua  | Completed      | Elementary/Secondary (0-12) College (1-4 or 5+)  | most of working life. DO NOT use re                                     | etired)              |                                       |  |
| 903(<br>within<br>iene<br>ier tha   | E C            |  | Farmhand  |                      | Farm                                  |  |
| 21215-0036 uld be filed within 7 Mental Hygiene marked other than event, the Medica   | BeC            | 17. Father's Name (First, Middle, Last)  |   | ne (First, Middle, N | Maiden Surname)                       |  |
| 212<br>ould be<br>1 Ment<br>is mark   | 삙              | Unk 19a. Informant's Name/Relationship (Type, Print ) 19b. Maill   | Unk ng Address (Street and Number o                                     | r Rural Route Num    | nber, City or Town, State             | , Zip Code)                                    |
| MD<br>id 2 sho<br>lith and<br>m 27 is   |                | Alfonso De Jesus / Son 8879  | W. Colonial Dri   |                      |                                       |  |
| Ore,<br>es l ar<br>of Hez<br>If ite   |                | 20a. Method of Disposition 20b. Place of Disposition Removal from State 20b. Place of Disposition or Community of Community (Community) and Community (Community) of Community (Community) and Community | osition (Name of cemetery, other place)                                 | Date                 | 20c. Location - City or               | Town, State                                    |
| Baltimore,<br>Permit. Pages I an<br>Department of He.<br>Important: If ite  |                | 4 Donation 5 Other Specify Capital ( 21. Signature of Funeral Service Licensee 22.   | Crematory 7/  | 14/2006              | Dover, DE                             |  |
| Bal<br>permi<br>Depar<br>Impo   |                |  | Bennieddesiiffich Fun<br>426 Dover Street                               |                      |                                       | 601  |
| Physician   | 7              | 23a Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.   |   |                      |                                       | Approximate Interval<br>Between Onset and      |
| /Medical<br>Examiner  |                | Immediate Cause (Final disease a Atherosclerotic Cardiovascular Di   | sease   |                      |                                       | Death  |
|   |                | or condition resulting in death)  Due to (or as a consequence of):   |   |                      |                                       |  |
|   | ē              | Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):   |   | ·                    |                                       |  |
|   | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Under the content of the conte |   |                      |                                       |  |
| executed<br>an and<br>al - transit  | cal Ex         | d.   |   |                      |                                       |  |
| ਰ ਲੋਵ   |                | UNPENDED   |   |                      |                                       |  |
| 876 tificate ing phy as the b   | W/U            | FFEMALE   23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1 Live birth   2   F   | Fetal death 3 Ectopic preg  | nancy                | 23d Date of delivery  Month D         | y<br>Day Year                                  |
| ox 6 ath cer attendi  | sician/Med     | Pregnant at time of death 5  | Other (Specify)   |                      | *                                     |  |
| ). Be the de by the ched f  | 된              | Part II. Other significant conditions contributing to death but not resulting in the   | e underlying cause given in Part I                                      | 23e. Did to          | bacco use contribute to               | the cause of death?                            |
| P.C cs that igned I be detail   | ক্র            |  |   | 1 🗸 Yes              | 2 No 3 Prob                           | ably 4 Unknown                                 |
| rds, requir   | Completed      |  |   | 24a. Was a           |                                       | topsy findings available ompletion of cause of |
| leco<br>he law<br>ate has   | E O            |  | _   | perfor               | med? death?                           |  |
| al R  | Be C           | 25 Was case referred to medical examiner?  | 26.Place of Death (Chec   | k only one)          |                                       | Lagi   |
| Physic<br>r this of   | 2              | 1 Yes 2 No Inpatient 2 ER/Outpatie   |   |                      | Residence 6 Other                     | Scene  |
| n of ding Ph  | .:<br>::       | 27. Manner of Death  28a Date of Injury (Month, Day, Year)  28b. Time o  | f Injury 28c. Injury at Work?   | 28d Describe r       | now injury occurred                   |  |
| ivisior or Atteno after death Director:   | icat           | 2 Accident Investigation 28e. Place of Injury - At home, farm, str   |   | 28f. Location (S     | Street and Number or Ru               | ral Route Number, City                         |
| Divisi<br>pital or Ati<br>ours after de<br>eral Direct  | Certification: | Suicide 6 Could not be determined (Specify)  |   | or Town, Si          |                                       |  |
|   |                | 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occ   |   |                      |                                       |  |
| To the Hos<br>within 24 h<br>To the Fur<br>completely   | Medical        | one) 2 Medical Examiner: On the basis of examination and/or investiged and manner stated.  29b Signature and title of certifier  | ation, in my opinion, death occurred                                    | at the time, date a  |                                       |  |
|   | ~              | Committee and time of certifier  | O.C.M.E.  |                      | 29d. Date signed (Mor<br>July 5, 2006 | nn, Day, rear)                                 |
|   |                | 30. Name and address of person who completed cause of death (Item 23a)   |   |                      |                                       |  |
| (2)   |                |  | Street, Baltimore, MD 212   | 01                   |                                       |  |
| Sta<br>Regist   | ate<br>rar     | MONN AL A 2311111 (SAME) - 1   | 100   |                      |                                       |  |
| Negist  | U.U            | JOL 1 1  |   |                      |                                       |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1Qa, b, c, e, f),Amended item# Registrar perFD, 06/30/06, TCHD Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Robert Lee Dale 2006 26 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and nymber) Examiner SKISHIN NICOMICO PENTILSULO Cente KegIONAL Medical 8. Date of Birth (Month, Day, Year) Sept. 12, 1944 Birthplace (State or Foreign Country) 5. Social Security Numb 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 11XM 2□ F 61 152-36-8497 Md. Director Usual Residence of Decedent 10c. City, Town or Location Salisbury Wicomico 10d. Inside City Limits death with the Maryland 10a. State yor health and Menial Hygiene.
If item 27 is marked other then "natural", or items 23a or 28a-f ehov or other traumatic event, the Modical Exercities in usi be notified at MD 1 Yes 2 No Director Delmar 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 203 E. College Ave. 21804 19940 USA 1605 Magnolia Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Mechanic 6th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked teny injury or other traumatic evone. Gladys Watford Dale Lawrence 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1605 Magnolia dr. Delmar, De. 19940 Marjorie Dale / Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Number 1 Number 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Acrees Ceme 7/1/06 Salisbury, Md. 21. Signat re of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 917 W. Isabella st. Salisbury, Md. 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LMNG CANLER YEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed attanding physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 PYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 ☐ Yes 2 No 1 Tyes ours after death.

Neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 🗀 Yes 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗀 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 141 000 62916 JUNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH DIVISION SUITEB SALISBURY MO 21804

State Registrar

31. Date filed (Month, Day, Year) JUN 2 9 2005

SVETLANA

1415

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month July Day 2006 Physician Marie Clair 5, Diangelis 9:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day, Year) 21 Birthplace (State or Foreign Country) **Funeral** Days Hours 198-07-6095 1 ☐ M 218 TF 85 Pennsylvania Director Usual Residence of Decedent the Maryland 10c. City, Town or Location ul Hygiene. other than "naturel", or Iteme 23a or 28a-f show vent, the Madical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Frederick 1 XYes 2 No Director Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 United States 1900 Rosemont Avenue Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 XMarried Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked Helen Pfau George Vorndran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoinette Smith / Daughter 7144 Poole Jones Rd., Frederick, MD 21702 Item 27 Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State July 8, Resthaven Crematory 4 Donation 5 Other (Specify) 2006 Frederick, Maryland eral Service Licalisee 21. Signatur 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Westers /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Medical Certification; Atter 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ۵ within 24 hours atter To the Funeral Direct 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 13051 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tou Home Are Bredirel MA Land 31. Date filed (Month, Day, Year) MOD egistrar's Signature State Registrar DHMH 17 Rev 1/2001

|                            |   |                | 1 - For<br>State<br>Registrar  | State of Maryland / Dep  | partment of H<br>e <i>rtificate of L</i>      |  |                                     | ene L U U ()                      | 4494   |
|----------------------------|---|----------------|--|--|---|--|-------------------------------------|-----------------------------------|--|
|                            | . typ   | - 1            | Decedent's Name (First, Middle, Last)  |  |   |  | 2. Date of Death                    |                                   | 3. Time of Death                               |
|                            | Physici   |                | Mary   | Dail   |   |  | June                                | Day Year 29 2006                  | 4:05 P <sup>M</sup>                            |
|                            | /Medic<br>Examin  |                | 4a. Facility Name (If not institution, give s                                  |  | 4b. City, Town, or                            | Location of Death                        |                                     | 4c. County of Death               |  |
|                            | LAGIIII   |                | 800 F. Stratford   | Wav  | Fred  | erick                                    |                                     | Frede                             | rick   |
|                            | Funeral   |                | 5. Social Security Number 6. Sex   | 7. Age (In yrs. last birthda   | y) II Under 1 Year                            | II Under 24 Hrs.                         | 8. Date of Birth                    | 9. Birth                          | place (State or Foreign                        |
| Н                          | Director  | 5 1            | 218-24-9869  | м 2 <b>X</b> F 82 Yrs.   | Months Days                                   | Hours Min.                               | (Month, Day, )<br>Aug. 14,          |                                   | yland  |
|                            | pu ,  |                | Usual Residence of Decedent  | 10- 0:- 7  |   |  |                                     |                                   |  |
|                            | anylai<br>show  | -              | 10a. State 10b. County   | 10c. City, Town or   | Location                                      |  |                                     |                                   | 10d. Inside City Limits<br>1 1 Yes 2 □ No      |
|                            | 8a-f  | cto            | Maryland Frederick   | Freder   |   |  |                                     |                                   |  |
|                            | or 2  | Directo        | 10e. Street and Number   |  | 10f. Zip Code                                 |  | 10                                  | g. Citizen of What Cou            | ntry?  |
|                            | ath v   | Funerai        | 800 F Stratfo  |  |   | 21701                                    |                                     | United Sta                        |  |
|                            | er de<br>item   | une            |  | 12. Was Decedent Ever in U.S. Armed Forces?  | . Was Decedent of Hi<br>If Yes, specify Cuba  | spanic Origin? (Sp<br>n, Mexican, Puerto | pecify Yes or No-<br>p Rican, etc.) | 14. Race - Ameri<br>Black, White, |  |
| 36                         | or or   | by F           | 1 Never Married 2 Married 3 StWidowed 4 Divorced                               | 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:   | 1 ☐ Yes 2 🂢 No                                | Specify:                                 |                                     | Specify:                          | Black  |
| 21215-0036                 | filed within 72 hours after death with the Maryland<br>Hygiene.<br>yther than "natural", or items 23s or 28s-1 show<br>her, the Medical Examinat must be rodified at  | edt            | 15. Decedent's Educ  |  | edent's Usual Occupa                          | ation                                    | 11                                  | 6b. Kind of Business/Ir           | vduetny  |
| 5                          | in 72<br>n" r   | Completed      | (Specify only highest grade  | e completed) (Gir  | re kind of work done of<br>DO NOT use retired | during most of world                     | king                                | DE. REING OF CUSHIOSSII           | idustry  |
| 72                         | with<br>iene.   | mo<br>m        | Elementary/Secondary (0-12)  | College (1-4or 5+)   | Registered                                    |  |                                     | Healthcar                         | a  |
| פ                          | i Hyg<br>othe   | Bec            | 17. Father's Name (First, Middle, Last)  |  |   |  | ne (First, Middle, Ma               |                                   |  |
| Maryland                   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Experiment at the notified at ODGs. | To B           | James Luther Whi   | ten  |   | Gussie H                                 | Harris                              |                                   |  |
| ary                        | shou<br>and N   | , it           | 19a. Informant's Name/Relationship (Type                                       | pe, Print) 19b. Ma   | iling Address (Street a                       | and Number or Ru                         | ral Route Number, (                 | City or Town, State, Zij          | Code)  |
| Σ                          | and 2   |                | Joan Thomas / Niec   | e 2501   | Driftwood                                     | d Court,2                                | D, Frede                            | rick, MD 2                        | L702   |
| altimore,                  | of He of He roth  |                | 20a. Method of Disposition   | 20b. Place of Dis  | position (Name of<br>ematory or other place   | θ)                                       | Date 20                             | oc. Location - City or To         | own, State                                     |
| Ĕ                          | Page<br>nent<br>ant: if   |                | 1 ☑ Burial 2 ☐ Cremation 3 ☐ R<br>4 ☐ Donation 5 ☐ Other (Specify)             | Resthave   | n Mem. Gar                                    | rd. 7/7/                                 | 2006                                | Frederick,                        | Maryland                                       |
| a                          | portr<br>portr<br>portr<br>y inju   |                | 21. Smature of Funeral Service License   | 90/  | 22. Name and Addres                           | s of Facility St                         | auffer Fu                           | ıneral Home                       | 9  |
| m                          | 8858  | 6 (0           | ( ountrees )   | auffer   | 1621 Ope                                      | ossumtown                                | ı Pike, Fı                          | rederick, N                       | ND 21702                                       |
| 6                          |   | (              | 23a. Part1. Enter the disease, or compli shock, or heart failure. List only or | cations that caused the death. Do not e  | nter the mode of dying                        | g, such as cardiac                       | or respiratory arres                | t,                                | Approximate<br>Interval Between                |
|                            | Physician   |                | Immediate Cause (Final disease or condition                                    | ( auditato   | M ~   | Alua                                     | ertens                              | 2000                              | Onset and Death                                |
|                            | /Medical  |                | resulting in death)  | Due to (or as a consequence of):   | 7   | 9/1                                      | -100                                | 31001                             |  |
|                            | Examiner  | V              | Sequentially list conditions, b  |  |   |  |                                     |                                   |  |
| 90                         | ם א   | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Due to (or as a consequence of):   |   |  |                                     |                                   | 2  |
|                            | and<br>trans  | am             | that initiated events resulting in death) Last                                 |  |   |  |                                     |                                   |  |
| ,<br>0                     | oe exi  | <u> </u>       | 103uting in coatiny cast   | Due to (or as a consequence of):   |   |  |                                     |                                   |  |
| 68760,                     | ficate be executed<br>physician and<br>is the burial-transit  | edicai         |  |  |   |  |                                     |                                   |  |
|                            | ertific<br>fing F   | Me             | IF FEMALE:   | 0- 14  |   |  |                                     |                                   |  |
| Вох                        | ath c   | ian            | 23b. Was decedent pregnant in the past 12 months?                              |  | □Ectopic pregnancy                            |  |                                     | 23d. Date of deliver              | ery<br>Day Year                                |
| P.O.                       | the a   | Physician/M    | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown  | 4☐ Pregnant at time of death 5 9☐ Unknown  | Other (specify)                               |  |                                     |                                   |  |
|                            | hat the   | Ph             | Part II. Other significant conditions con                                      | tributing to death but not resulting in the  | underlying cause give                         | on in Part I                             | 23e Did toba                        | cco use contribute to t           | he cause of death?                             |
| ရှိ                        | The law requires that the death certi<br>tie has been signed by the attending<br>page 2 should be detached for use a  | 1 by           |  | and the document of the life   | andonying oxago give                          | ariar arri.                              |                                     | 2 □ No 3 □ Prot                   |  |
| Ö                          | requ  | Completed      |  |  |   |  |                                     |                                   | ,  |
| 3ec                        | elaw<br>hasl  | mpi            |  |  |   |  | 24a. Was an autopsy                 | 24b. Were auto                    | psy findings available<br>mpletion of cause of |
| <u></u>                    | : Th<br>cate<br>pag   | S              |  |  |   |  | performe                            |                                   | 2 No   |
| Ĭ,                         | ician<br>Sertifi<br>ector   | Be             | 25. Was case referred to medical examiner?                                     | osnital:   | 1 040   |  | th Check only one                   |                                   |  |
| 5                          | Phys<br>this<br>al dir  | 7              | 1 163 2 0  | ospital:   |   | 4   Nursing H                            |                                     | ce 6 Other (Specif                | y)   |
| n c                        | Jing After  | ioi            | 27. Manner of Death 1 ☐ Natural 5 ☐ Pending                                    | 28a. Date of Injury<br>(Month, Day Year) 28b. Time<br>Injury   | Work  |  | 28d. Describe how                   | injury occurred                   |  |
| <u>.</u>                   | Attending Physician: or death. ector: After this certifice by the funeral director. (   | icat           | 2 Accident investigation 3 Suicide 6 Could not be                              | 290 Place of Injury. At home, form   |   | fes 2 □ No                               | 291 Location (Stro                  | ot and Number or Bur              | J. Co. et M. mba                               |
| Division of Vital Records, | or A<br>after<br>Direct   | Certification: | 4 Homicide determined  | 28e. Place of Injury - At home, farm, s<br>building, etc. (Specify)  | street, factory, office                       |  | City or Town,                       | et and Number or Rura<br>State)   | il Houte Number,                               |
| _                          | spital<br>ours<br>neral<br>filled   |                | 29a. Certifier 1 Certifying Phys   | ician: To the best of my knowledge, de   | ath occurred at the tim                       | e date and place                         | and due to the cau                  | so/s) and manner as s             | tated  |
|                            | Hospital     24 hours a     Funeral letely filled   | edicai         | (Check only 2 Medical Examination)   | ner: On the basis of examination and/or and manner stated.   | investigation, in my op                       | pinion, death occur                      | red at the time, date               | e and place, and due to           | the cause(s)                                   |
|                            | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2   | Me             | 29b. Signature and title of certifier  |  | 29c. License                                  | number                                   | 290                                 | I. Date signed (Month,            | Day, Year)                                     |
|                            |   |                | 1 600  | and at mac   | ONT   | C1091                                    | 00                                  | 116/30                            | 124  |
|                            | $\bigcap$   |                | 30. Name and address of person who co  | mpleted cause of death (Item 23a) (Type  | e, Print) 11(2)                               | Bar 17                                   | mond?                               | SLOWE                             | )  |
|                            | •   |                | AZEB JESFA   | LEDG MO  | 110   | edente                                   | Le, 7                               | MO 31                             | 702  |
|                            | Sta   |                | 31. Date liled (Month, Day, Year)  | 32 Registrar's Signature   |   |  |                                     |                                   |  |
|                            | Registr   |                | 1111 <b>1 0 2</b> 00   | In I de la company of the second of the seco |   |  |                                     |                                   |  |

| - E  |   | 1 - State<br>Registrar Am   |  | a QACHD7/0   | //06bsr  | Certifica  | ie oi i   | Death  | 2. Date of  | Reg. No  | э.  | 3. Ti   | me of Death  |
|--|---|---|--|--|--|--|---|--|---|--|---|---|--|
| ysicia   |   |   | 1,1  |  | 1  | 0 - "  | ( , ( , -   | CITA   | Month   | Da   | ,   | ar  | 230 M  |
| Medic:<br>kamine   |   |   | ESTE   | ive street and number)   |  |  |   | Location of Dea  |   |  | . County of E   |   | 130_   |
|  | ٠.<br>٤.٤   | CHESTE  | RIUSER   | HOSPITA  | 1 CENT   | FR   | CH  | ESTER!   | TOWN  |  | KER   | ,   |  |
| neral  |   | 5. Social Security N  | lumber 6.  | Sex 7. Ag<br>1 <b>X</b> M 2 ☐ F  | e (In yrs. last b  | irthday) If Unde   |   | If Under 24 Hr<br>Hours Min  | . (Month,   | Day, Year,   | 9.  | Birthplace (S<br>Country)   | State or Foreign   |
| ctor   |   | 177-30-90<br>Usual Residence of   |  | 66   | 6  | Yrs.   |   |  | MAY 8   | ,1940  | ) P   | ENNSÝL  | VANIA  |
| event, the Medical Examinat must be notified at  | ľ   | 10a. State  | 10b. County  |  | 10c. City, Tox   | wn or Location   |   |  |   |  |   | 10d. Ins  | ide City Limits  |
|  | tor   | MD  | QUEEN A  | ANNE   | CEI  | NTREVILL   | Æ   |  |   |  |   | 1 💆   | Yes 2 No   |
|  | Funeral Director  | 10e. Street and Nu  | mber   |  |  | 10f. Z   | ip Code   | 1617   |   | 10g. Ci  | itizen of Wha   | t Country?  |  |
|  | al  | 105 QUAI  | L LANE   |  |  |  |   | 1617   |   |  | USA   |   |  |
|  | nuel  | 11. Marital Status  | _  | 12. Was Decedent<br>Armed Forces?  | ?  | 13. Was Dec  | edent of H<br>ecify Cuba  | ispanic Origin?<br>In, Mexican, Pue  | Specify Yes or<br>into Rican, etc.)   | No-  |   | American Indi<br>White, etc.  | an,  |
|  | by F  | 1 Never Marr  | ied 2. Married<br>4. □ Divorced  | 1 ☐ Yes 2 📉<br>If Yes, Give<br>Year or Dates:  | No   | 1 🗆 Yes  | 2 <b>X</b> No   | Specify:   |   |  | Specify:  | WHITE   |  |
|  |   |   | 15. Decedent's E   | Education  | 168  | a. Decedent's Us   | sual Occup  | ation  | · · · · · · · · · · · · · · · · · · ·   | 16b. H   | Kind of Busine  | ess/Industry  |  |
|  | Completed   | (Spec   | ondary (0-12)  | rade completed) College (1-4or:  | 5+)  | (Give kind of w<br>life. DO NOT  | vork done o<br>use retired  | during most of w   | orking  |  |   |   |  |
|  | Nom   | 12  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,   | -0-  |  | TRUCK  | DRIV  | ER   |   | TID  | EWATER  | PUBLI   | SHING  |
|  | Be  | 17. Father's Name   |  |  |  |  |   |  | ame (First, Midd  |  | n Sumame)   |   |  |
|  | 2   | LESTER  | A. DOWN  | ES, SR.  |  |  |   | MABI   |   |  |   |   |  |
|  |   | 19a. Informant's N  | ame/Relationship - DOWNES  |  | 19   | b. Mailing Addres  O5 QUATI  | ss (Street  | and Number or I<br>E . CENTI   | REVILLE,  | mber, City<br>MD   | or Town, Sta.<br><b>21617</b>   | te, Zip Code)   |  |
|  |   | CYNTHIA<br>20a. Method of Dis   |  |  |  | of Disposition (N  |   |  | Date  |  | ocation - City  | y or Town St  | ato  |
|  |   | 1 XBurial 2   | Cremation 3  | ☐Removal from State  | cemete   | ery, crematory or<br>ERFIELD   | other plac  | (e)  <br>FDV   7_6   |   |  | REVILI  |   |  |
|  |   | 4 ☐ Donation  21. Signature of #1   | 5 Other (Spec  |  | CHESIL   | 22 Name  | and Address   | es of Eagliby  |   |  |   |   |  |
|  |   | 1/6   | 1 M  | The  | ,  | FELLOV   | IC HE   | TENRETI  | W & NEWN  | IAM F  | IINERAT.  | HOME.   | P.A.   |
|  |   |   |  |  |  | THEOT  | 10,1116   | PLEKDETI   | O III   | . TITTTT '   |   | 21617   |  |
|  |   | 23a. Part1. Enter t   | he disease, or cor   | mplications that cause   | d the death. Do  | 408 S  | LIB   | ERTY ST  | CENTI   | REVIL  | LE, MD  | 21617<br>Appro  | ximate   |
| ۱  |   | Immediate Cause   | (Final   | mplications hat caused<br>y one cause on each li   | d the death. Do  | 408 S.   | LIB<br>ode of dyin  | ERTY ST<br>ig, such as cardi   | cENTI   | REVIL.<br>rarrest,   | LE, MD  | 21617<br>Appro  |  |
|  |   |   | (Final   | mplications that caused y one caused in each li  | d the death. Do  | 408 S.   | LIB<br>ode of dyin  | ERTY ST<br>ig, such as cardi   | cENTI   | REVIL.<br>rarrest,   | LE, MD  | 21617<br>Appro  | ximate<br>al Between   |
|  |   | Immediate Cause<br>disease or condition<br>resulting in death)  | (Final<br>on   | a. CARL  Due to (or as   | d the death. Do  | 408 S.   | LIB<br>ode of dyin  | ERTY ST<br>ig, such as cardi   | cENTI   | REVIL.<br>rarrest,   | LE, MD  | 21617<br>Appro  | ximate<br>al Between   |
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|  | Examiner  | Immediate Cause disease or condition resulting in death)  Sequentially list confirm any, leading to incause. Enter Unde Cause (Disease or Cause)  | (Final on on of the conditions, on of the conditions, on of the conditions of the co | a. CARL Due to (or as  b. Due to (or as  c.  | Siopula<br>a consequence   | 408 S. po not enter the mo  covary e of):  Liven e of):  | LIB<br>ode of dyin  | ERTY ST<br>ig, such as cardi   | cENTI   | REVIL.<br>rarrest,   | LE, MD  | 21617<br>Appro  | ximate<br>al Between   |
|  | a   | Immediate Cause disease or condition resulting in death)  Sequentially list confiancy, leading to incause. Enter Under Cause (Diseases or that initiated events)  | (Final on on of the conditions, on of the conditions, on of the conditions of the co | a. CARL Due to (or as  b. Due to (or as  c.  | s a consequence  HATI'S s a consequence  | 408 S. po not enter the mo  covary e of):  Liven e of):  | LIB<br>ode of dyin  | ERTY ST<br>ig, such as cardi   | cENTI   | REVIL.<br>rarrest,   | LE, MD  | 21617<br>Appro  | ximate<br>al Between   |
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|  | a   | Immediate Cause disease or condition resulting in death)  Sequentially list confirm, leading to incause. Enter Under Cause (Disease or that initiated events resulting in death)  IF FEMALE: 23b. Was decedent  | (Final on on of the conditions, mediate strying injury states to the conditions of t | a  | s a consequence a consequence a consequence a consequence of pregnancy   | 408 S. contenter the mo  Covary e of):  Liven e of):   | LIB ode of dyin Anz Can pregnancy   | ERTY ST g, such as cardi  ROST   | cENTI   | REVIL.<br>rarrest,   | I.E, MD   | Appro-<br>Interv<br>Onsei   | oximate<br>al Between<br>and Death                                 |
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|  | by Physician/Medical  | Immediate Cause disease or condition resulting in death)  Sequentially list confirmly leading to incause. Enter Under Cause (Disease or that initiated events resulting in death)  IF FEMALE: 23b. Was deceden in the past 12 1   | (Final on the conditions, mediate arriving injury state that pregnant months?  | a  | s a consequence a consequence a consequence a consequence b of pregnancy 2 Fetal deat t time of death  | 408 S. p not enter the mo  Covary e of):  Liven e of):  th 3 Ectopic 5 Other (s  | Cath  | ERTY ST g, such as cardi ROST  | ac or respiratory   | REVII.   | 23d. Date of Month  | Appropriate of delivery Day   | ximate<br>al Between<br>and Death                                  |
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|  | by Physician/Medical  | Immediate Cause disease or condition resulting in death)  Sequentially list confirmly leading to incause. Enter Under Cause (Disease or that initiated events resulting in death)  IF FEMALE: 23b. Was deceden in the past 12 1   | (Final on the conditions, mediate arriving injury state that pregnant months?  | a  | s a consequence a consequence a consequence a consequence b of pregnancy 2 Fetal deat t time of death  | 408 S. p not enter the mo  Covary e of):  Liven e of):  th 3 Ectopic 5 Other (s  | Cath  | ERTY ST g, such as cardi ROST  | 23e. Di 10 24a. W   | d tobacco Yes 2 as an topsy  | 23d. Date of Month  use contribut  2 No 3   | delivery Day  Probably  e autopsy fine to completion h?   | Year  Year  4 Unknown  dings available n of cause of               |
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|  | Medical Certification: To Be Completed by Physician/Medical | Immediate Cause disease or condition resulting in death)  Sequentially list confirmly leading to incause. Enter Under Cause (Disease or that initiated events resulting in death)  IF FEMALE: 23b. Was deceden in the past 12 1   | inditions, mediate striying striying sinjury streed to medical months?  No  Treed to medical months and months?  No  The conditions investigate and determine are striping str | a. Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 \( \triangle \trian | a consequence  a cons | 408 S. contenter the more covering a of):  2 / Ven e of):  th 3   Ectopic 5   Other (state of the country of th | pregnancy specify) acause give 28c. Injure 200A Oth Orry, office and at the time, in my office. | en in Part I.  26. Place of Der: 4 Nursing yat k? Yes 2 No   | 23e. Di  24a. W  24a. W  28d. Describ  28d. Describ  28f. Location City or i    | d tobacco  Yes 2  as an anopsy offormed?  So 2 No.  Young)  assidence  the how injutation of the cause(see, date and 29d. Date 29d. Date 29d. Date 29d. Date 29d. Date 29d. Date 39d. Date | 23d. Date of Month  use contribut  24b. Wern prior deat 1 1 6 Other (3 in y occurred)  and Number of e)  s) and manned d place, and ate signed (Manuel of the signed (Manuel of | a 21617 Approximate to the cause Probably e autopsy finite to completion h? Yes 2 N Specify) or Rural Route or as stated, due to the ca | Year  Year  4 Unknown  dings available n of cause of o             |

DHMH 17 Rev 1/2001

ORIGINAL

|  |  |                |   | State of Maryland<br>en/E, 858, 8/14/06   |  |   |  |  | 0000                                 |
|--|--|----------------|---|---|--|---|--|--|--------------------------------------|
|  |  |                | Registrar   | enur, g858,8/14/06  | Certific                                   | ate of Death  | Rag.   | No.  | 14900                                |
| >  | Physici  |                | 1. Decedent's Name (First, Middle, Last)  | ES DENA   | 1. 5                                       |   | 2. Date of Death<br>Month                          | Day Year   | ime of Death                         |
|  | /Medi<br>Examir  |                | 4a. Facility Name (If not institution, give s   |   |  | City, Town, or Location of Deal                                     | h July   | 4c. County of Death  | 546 M                                |
| 0,   |  |                | FeWINSULA REGIONAL 5. Social Security Number 6. Sex   |   | St highday) If U                           | SAUSBY<br>nder 1 Year   If Under A Hrs                              | 9 Date of Birth                                    | Wiconico   | State or Foreign                     |
| 7-54   | Funeral<br>Director  |                |   | tm 2□F 55   | Yrs. Mon                                   |   |  | 9. Birthplace (S<br>Country)                               | 1D                                   |
| 2/1/2  | Maryland<br>s-f show   | tor            | 10a. State 10b. County  MD SOMERS   | ET RIA  | Town or Location                           | ANNE  |  | 12   | ide City Limits<br>Yes 2 ☐ No        |
| . 3  | with the a or 28s  | Director       | 10e. Street and Number  | A . =   |  | . Zip Code  | 10g.   | Citizen of What Country?                                   |                                      |
| Chi  | death ms 234   | Funeral        | 11250 HACC<br>11. Marital Status  | 12. Was Decedent Ever in U.S  | . 13. Was D                                | ecedent of Hispanic Origin? (S                                      | Specify Yes or No-                                 | 14. Race - American Indi                                   | ian,                                 |
| ر 9 <b>د</b> 0   | s 1 and 2 should be filed within 72 hours after death with the Marylar f Health and Mental Hygiene. Item 27 is marked other tren "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at   | b              | 1 Never Married 2 Married 3 Widowed 4 Divorced  | Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:                            |  | specify Cuban', Mexican', Puèr<br>is 25 No Specify:                 | to Hican, etc.)                                    | Specify: BLA   | CK                                   |
| aluer<br>21215-003   | n 72 ho<br>"natur  | Completed      | 15. Decedent's Educ<br>(Specify only highest grade  | completed)  | 16a. Decedent's (Give kind o. life. DO NO  | Usual Occupation<br>f work done during most of wo<br>T use retired) | rking 16b  | . Kind of Business/Industry                                |                                      |
| 212  | giene.   | Somp           | Elementary/Secondary (0-12)   | College (1-4or 5+)  | TRUCK                                      | < DRIVE F   | z Ji   | OHN HILL IR  | veking                               |
|  | should be filed within nd Mental Hygiene. marked other then umatic event, the Mental control of the Mental con | Be             | 17. Father's Name (First, Middle, Last)   | TORON   |  | A A   | me (First, Middle, Maid                            | ten Sumame)  | 2:/0(                                |
| $\left( egin{array}{c} \egin{array}{c} \egin{array}{c} \egin{array}{c} arr$ | should<br>ind Men<br>marke   | ြင             | 19a. Informant's Name/Relationship (Type  | ES DOANE  |  | ress (Street and Number or R  | ural Route Number, Ci                              | ty or Town, State, Zip Code)                               | NIS                                  |
|  | end 2<br>ealth a<br>m 27 is  | 1 15           | MAMIE E. WHITE-   | - MOTHER  | 502 Pur                                    | RNELLST S   | ALISBURY   | Mp 21801   | İ                                    |
| nore   | Peges 1<br>nent of H<br>int: If ite  |                | 20a. Method of Disposition  1 □Surial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify)             | emoval from State   | nce of Disposition metery, crematory       | (Name of or other place)  | Date 20  | Location - City or Town, Sta                               | ate                                  |
| Baltimore,   | permit. Peges 1 end 2<br>Department of Health a<br>Important: if item 27 is<br>eny injury or other tra<br>once.  |                | 21. Sign yure of Funeral Service License  |   | DLING H                                    | e and Address of Facility   | ENDIES   | WITH FIH   | , 11(D                               |
| 0  | 89 5 8   | 1 0            | Muscella  | Enrich  | 1 917.0                                    | U. ISABELLAS  | ST. SALISE   | BURY, MD. 21   | 1801                                 |
|  | Dhysisian  |                | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final | e cause on each line.   | Do not enter the                           | mode of dying, such as cardia                                       | c or respiratory arrest,                           | Interv   | eximate<br>al Between<br>t and Death |
|  | Physician<br>/Medical  |                | disease or condition resulting in death)  | Due to (or as a conseque  | ence of):                                  |   |  |  |                                      |
|  | Examiner   | -              | Sequentially list conditions, b   |   | ance of                                    |   |  |  |                                      |
|  | outed<br>od<br>ransit  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events                                  |   |  |   |  |  |                                      |
| 760,   | be executed<br>sicien and<br>burial-transit  |                | resulting in death) Last  | Due to (or as a conseque  | ence of):                                  |   |  |  |                                      |
| 89   | 0 0  | edical         | d   |   |  |   |  |  |                                      |
| Вох  | eath certificate be ex<br>attending physicien<br>for use as the buria  | Physiclan/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  | 3c. If yes, outcome of pregnan  |  | ic pregnancy  |  | 23d. Date of delivery<br>Month Day                         | Man.                                 |
| P.O. E   | the dea<br>y the at<br>ched fo   | ysici          | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4☐ Pregnant at time of dea<br>9☐ Unknown  | ath 5 Other                                | (specify)   |  | Month Day  | Year                                 |
| ds, P.   | The law requires that the death certifical site has been signed by the attending phypage 2 should be detached for use as the   | þ              | Part II. Other significant conditions con   | tributing to death but not resul  | ting in the underlyi                       | ng cause given in Part I.   |  | co use contribute to the caus                              |                                      |
| cor  | w requ   | Completed      |   |   |  |   | 24a. Was an  | 24b. Were autopsy find                                     |                                      |
| Re   |  | Comp           |   |   |  |   | autopsy<br>performed<br>1 ☐ Yes 2 【2               | prior to completion death?                                 | n of cause of                        |
| Vita   | ician:<br>certific<br>rector.  | Be             | 25. Was case referred to medical examiner?  | ospital:  |  | 100   | ath (Check only one)                               |  |                                      |
| Division of Vital Records,   | ig Phys<br>ter this<br>neral di  | n: To          | 27. Manner of Death   | 1 □ Inpatient 2 LM E  | 28b. Time of Injury                        | DOA 4 Nursing I   | lome 5 ☐ Residence<br>28d. Describe how in         | e 6 ☐Other (Specify)                                       |                                      |
| sior   | tendin<br>death.<br>tor: Af<br>the fur   | catlo          | 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be                          |   | М  | 1 ☐ Yes 2 ☐ No  |  |  |                                      |
| Divi   | s after of bit of by   | Certification: | 4 Homicide determined   | 28e. Place of Injury - At hon building, etc. (Specify)                            | ne, tarm, street, ta                       | ctory, office   | City or Town, St                                   | t and Number or Rural Route<br>tate)                       | Number,                              |
|  | To the Hospital or Attending Phwithin 24 hours after death.  To the Funerel Director: After the completely filled in by the funeral  | Medical        | 29a. Certifier 1 Certifying Phys<br>(Check only one) 2 Medical Examin                                   | sician: To the best of my knowner: On the basis of examination and manner stated. | rledge, death occur<br>on and/or investiga | rred at the time, date and place<br>tion, in my opinion, death occ  | e, and due to the cause<br>urred at the time, date | e(s) and manner as stated,<br>and place, and due to the ca | use(s)                               |
|  | To th<br>To th<br>con p  | Me             | 29b. Signature and title of certifler   |   | An   | 29c. License number   | 29d.   | Date signed (Month, Day, Ye                                | 3ar)                                 |
|  | - MA   |                |   |   |  | 400-74  | 0  | 118/06   | _                                    |
|  | 700  |                | 30. Name and address of person who co   | mpleted cause of death (Item.   | estate industrial                          | cury 2  | 8-1  |  |                                      |
|  | St<br>Regist   | ate            | 31. Date filed (Month, Day, Year)   | 32. Panistrar's Signatu   |  | N .   |  |  |                                      |
|  | negist   | ul             | I 0 LC  | Partition )   | Ch. SHOW                                   |   |  |  |                                      |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 0702 M Robert Charles Dunlap 07 03 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER PENINSULA REGIONAL MEDICAL SKISKING NICOMICO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yea 6/23/1951 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X**M 2□ F Hours 223-76-1916 55 Director Delaware Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at XX Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 313 Maple Way 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Wes 2 ☐ No If Yes, Give Year or Dates: Navy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ white 3 ☐ Widowed 4 ☐ Divorced Navy Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Trucking 12 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any lighty or other traumatic event spice. Robert E. Dunlap Barbara A. Donovan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Artrip/daughter 313 Maple Way, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Gracelawn Cemetery 7/7/06 4 ☐ Donation 5 ☐ Other (Specify) Wilmington, DE 21. Signature of Funeral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ASCVO Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy signed by tha atte d be detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Kunknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funerel Director: Affer this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No 1 Inpatient 2 X R/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 40057410 completed cause of death (Item 23a) (Type, Print) ENG SIMONA 100 E Carray ST. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JUNE 28 CHARLES EMERY ENNIS 2006 9:45AM M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT HOSPICE HOUSE EASTON TALBOT 8. Date of Birth (Month, Day, Year) JUNE 6, 1926 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F **Funeral** Days Hours OHIO Yrs 80 Director 299-18-8726 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes No Director QUEEN ANNE'S QUEENSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21658 USA or Items 23a 208 WALNUT DRIVE by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "netural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) VICE PRESIDENT CONSULTING FIRM 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) E. RAYMOND ENNIS HENRIETTA EMERY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is in any injury or other traum once. HARRIETT H. ENNIS/WIFE 208 WALNUT DRIVE, QUEENSTOWN, MD 21658 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR. 6/30/2006 STEVENSVILLE, MD \* 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Joseph M. (STROUNG 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Carcinoma MINOW disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 2 0 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No 1 ☐ Yes 2 No Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XOther (Specify) HOSPICE Hospital 은 1 Yes 2 No 1 Inpatient 2 EP/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai within 2 To the

6+1VA

CHARLES ENVIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) III M.D., 503 CYNWOOD DR., EASTON, MD 21601 J. EGLSEDER, LUDWIG

FW

State Registrar

JUN 3 0 2006

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



29c. License number

31466

29d. Date signed (Month, Day, Year)

|                    |  |                          | For State Registrar   | State of Man   | -                     | •                                 | nt of Hea<br>te of De              |                                     | lental Hy                              | giene<br>Reg. No.                | 06                              | 22989  |
|--------------------|--|--------------------------|---|--|-----------------------|-----------------------------------|------------------------------------|-------------------------------------|--|----------------------------------|---------------------------------|--|
|                    | Dharais  |                          | 1. Decedent's Name (First, Middle, Last)  |  |                       |                                   |                                    |                                     | 2. Date of De                          | eath<br>Day                      | Year                            | 3. Time of Death                                   |
|                    | Physici<br>/Medi   |                          | MILTON  | F. EVAN  | NS S                  |                                   |                                    |                                     | Tuly                                   | 10                               | 2001                            | 1640M  |
|                    | Examir   |                          | 4a Facility Name (If not institution, give stre   | nedical (  | enter                 | 4b. City                          | alist                              | cation of Death                     |  | 4c. Cour                         | City of Death                   |  |
| Ī                  | Funeral<br>Director  |                          | 5. Social Security Number / 6. Sex<br>216-22-3951 「類M   | 7. Age (//   | n yrs. last birtho    | Months                            |                                    | Under 24 Hrs.<br>Hours Min.         | 8. Date of Bil<br>(Month, Di<br>Mar. 2 | nth<br>ay, Year)<br>, 1926       | Cour                            | otace (State or Foreign<br>otry)<br>71and          |
|                    | and w  |                          | Usual Residence of Decedent  10a. State 10b. County   | 10   | Oc. City, Town o      | r Location                        |                                    |                                     |  |                                  | 1                               | 0d. Inside City Limits                             |
|                    | Marylan<br>f ehow<br>led al  | ŏ                        | Maryland Somerset   | ;  |                       | Rhode                             | s Poin                             | .t                                  |  |                                  |                                 | 1 ☐ Yes 2 ☑No                                      |
|                    | 1 the  | Director                 | 10e. Street and Number  |  |                       | 10f. Z                            | p Code                             |                                     |  | 10g. Citizen o                   | f What Cour                     | ntry?  |
|                    | death with the Maryland<br>ms 23a or 28e-f ehow<br>rmust be notified at  |                          | 3411 Marsh Road   |  |                       |                                   | 218                                | 24                                  |  | U.S.                             | Α.                              |  |
|                    |  | Funeral                  | 11. Marital Status 12.  | Was Decedent Eve<br>Armed Forces?                                  | er in U.S.            | 13. Was Dec                       | edent of Hispa                     | anic Origin? (Sp<br>Mexican, Puerto | ecify Yes or No                        | o- 14. R                         | ace - Americack, White,         |  |
| 9                  | o after  | y Fu                     | 1 Never Married 2 Married   | 1 to Yes 2 □ No If Yes, Give                                       | World                 | 1 ☐ Yes                           |                                    | Specify:                            | , , , , , , , , ,                      | Spec                             | ifv.                            |  |
| ٤٤                 | ural.  | ed by                    | 3 ∑Widowed 4 ☐ Divorced  15. Decedent's Educat  | Year or Dates:   | War II                |                                   |                                    | -                                   |  | 16b. Kind of                     | Whi                             |  |
| 2 4                | within 72 hours after<br>ene.<br>than "natural", or Ite  | ojet                     | (Specify only highest grade of  | om <i>pleted)</i>  | 10a. D                | Give kind of w<br>fe. DO NOT      | ork done duri<br>use retired)      | n<br>ng most of work                | ing                                    | 160. Kind of                     | Duzinezzin                      | dustry   |
| $\sim 2$           | y with   | Completed                | Etementary/Secondary (0-12)   | College (1-4or 5+)   |                       | tmaste                            |                                    |                                     |  | U. S.                            | Posta                           | 1 Service  |
| $\frac{\omega}{2}$ | be filed<br>ital Hygin<br>d other  | Be C                     | 17. Father's Name (First, Middle, Last)   |  |                       |                                   | 18                                 | . Mother's Nam                      | e (First, Middle                       | , Maiden Suma                    | ime)                            |  |
| 1+2×               | should b<br>and Ments<br>a marked<br>umatic e  | 10                       | Benjamin Franklin B   |  |                       |                                   |                                    | Essie                               | Evans                                  |                                  |                                 |  |
| - L                | 2 short and and raum   |                          | 19a. Informant's Name/Relationship (Type,   |  |                       |                                   |                                    | Number or Rui                       |  |                                  | n, State, Zip                   | Code)  |
| 4                  | Tand 1 and Health Health ther tr   |                          | Vivian E. Evans (Wi   |  | 34<br>20b. Place of D |                                   |                                    | d - Rho                             | des Poi                                | nt, MD<br>20c. Location          | 2182                            |  |
| <u>_</u> _ 2       | Pages<br>nent of lint: If it   |                          | 1⊠ Burial 2 ☐ Cremation 3 ☐ Rem   | oval from State  | cemetery,<br>Calvary  | crematory or                      | other place)                       | !                                   | 5/06                                   |                                  |                                 | nt, MD   |
| Milter Eugh        | Deficiency Man yield A 12 12 13 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   |                          | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licessee                                 |  | // Carvary            |                                   | and Address o                      |                                     | 3,00                                   | MIOCC                            | 3 1011                          | ic, in   |
| å                  | permit. Departiment in port  |                          | · Kolite fina   | chliff   |                       | _306. V                           | . Main                             | Sons Fu<br>St C                     | risfiel                                | d. MD                            | 2181,7                          |  |
|                    |  |                          | 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one                         | tions that gadsed the<br>cause on each line.                       | e death. Do not       | enter the mo                      | de of dying, s                     | uch as cardiac                      | or respiratory a                       | rrest,                           |                                 | Approximate<br>Interval Between<br>Onset and Death |
| 0                  | Physician  |                          | Immediate Cause (Final disease or condition resulting in death)   |  | emia                  |                                   |                                    |                                     |  |                                  |                                 |  |
|                    | /Medical<br>Examiner   |                          |   | Due to (or as a c  |                       | :                                 |                                    |                                     |  |                                  |                                 |  |
|                    | *  | ē                        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a c  | chandneuce of)        | 4                                 |                                    |                                     |  |                                  |                                 |  |
|                    | executed<br>executed<br>in and<br>ial-transit  | Examiner                 | cause. Enter Underlying Cause (Disease or injury that initiated events                                      | COPD   |                       |                                   |                                    |                                     |  |                                  |                                 |  |
|                    | be executed ician and burial-transit   |                          | resulting in death) Last  | Due to (or as a c  | onsequence of)        | 4                                 |                                    |                                     |  |                                  |                                 |  |
| 270                | phys<br>the  | dicai                    | d   | lobac  | CO 0                  | (pn21                             | 2                                  |                                     |  |                                  |                                 |  |
| 3                  | BOX OF BOAR OF A CONTINUE OF THE CONTINUE OF T | n/Me                     | IF FEMALE: 23b. Was decedent pregnant 23c.  | If yes, outcome of p   |                       |                                   |                                    |                                     |  | 23d. D                           | ate of delive                   | ery  |
| in a               | ne death<br>the atte   | sicia                    | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 1☐Live birth 2 [<br>4☐Pregnant at tim<br>9☐ Unknown                |                       | 3 ☐ Ectopic  <br>5 ☐ Other (s     |                                    |                                     |  | ٨                                | Nonth .                         | Day Year   |
| M                  | T.C.   | Phy                      | 9 ☐ Unknown  Part II. Other significant conditions contril  |  | not reculting in th   | an underhing                      |                                    | n Port I                            | 230 Did                                | lohacco uso co                   | atributo to ti                  | ne cause of death?                                 |
| OK pume            | VICAL MECOLOS, P.O. BOX of sicien: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as   | Completed by Physician/M | HTN   | outing to death but h  | iot resulting in th   | ie dilderlying                    | Cause given i                      | iraiti.                             | 1)                                     | Yes 2□No                         | 3 ☐ Prob                        |  |
| 7                  | w requ   | olete                    | Acute Ronal F   | allure   | •                     |                                   |                                    |                                     | 24a. Was                               | an 24b                           | . Were auto                     | psy findings available mpletion of cause of        |
| 1                  | VICAL TRE<br>vician: The lav<br>certificete hes<br>rector, page 2  | mo                       |   |  |                       |                                   |                                    |                                     | auto<br>perfe                          | psy<br>ormed?<br>2 XNo           | prior to co<br>death?<br>1  Yes |  |
| 3                  | Or VICA<br>Physician:<br>this certifical   | Be                       | 25. Was case referred to medical examiner?  |  |                       |                                   |                                    | S. Place of Deal                    |  |                                  |                                 |  |
|                    | Physic<br>Physic<br>this co  | ုင                       | 1 □ Yes 2 No  | pital: 1 Inpatient   | 2 ER/Outp             |                                   |                                    | 4 Nursing Ho                        |  |                                  |                                 | y)   |
| 2                  | ding F   | tlon:                    | 27. Manner of Ďeath  1 ☑Naturat 5 ☐ Pending 2 ☐ Accident investigation                                      | 28a. Date of Injury<br>(Month, Day Y                               | ear) 28b. Tin         | ne of<br>iry<br>M                 | 28c. Injury at<br>Work?<br>1 ☐ Yes | 2 □No                               | 28d. Describe                          | how injury occi                  | ırred                           |  |
| Ta                 | UIVISION OI  I or Attending Phys after death. Director: After this   | Certification:           | 2 Suicide 6 Could not be  | 28e. Ptace of Injury<br>building, etc. (                           | - At home, farm       |                                   |                                    |                                     |  | Street and Nun<br>wn, State)     | nber or Rura                    | I Route Number,                                    |
| Ċ                  | Itel or<br>irs afte<br>rei Dir   |                          |   |  |                       |                                   |                                    |                                     |  |                                  |                                 |  |
|                    | To the Hospitel or Attending Physician: The lawithin 24 hours after death.  To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2   | edical                   | 29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examiner                                      | ian: To the best of n<br>: On the basis of ex<br>and manner stated | camination and/c      | leath occurre<br>or investigation | d at the time,<br>n, in my opini   | date and place,<br>on, death occur  | and due to the<br>red at the time,     | cause(s) and r<br>date and place | nanner as s<br>, and due to     | tated.<br>the cause(s)                             |
|                    | To the within 2<br>To the complet  | Ž                        | 29b. Signature and title of certifier   |  |                       | 2                                 | c. License n                       | umber                               |  | 29d. Date sign                   | ed (Month,                      | Day, Year)   |
|                    |  |                          | · WIVIN   | MI   | )                     |                                   | 063                                | 499                                 |  | 0+17                             | 1010                            | 16   |
|                    |  |                          | 30. Name and address of person who comp   | Deleted cause of deat  | th (Item 23a) (Ty     | (pe, Print)                       | + Pr                               | INCOST                              | Anne                                   | MD 6                             | 1185                            | 3  |
|                    |  | ate                      | 31. Date filed (Month, Day, Year)   | 32. Registrar's  |                       | 1                                 | -4                                 |                                     |  |                                  |                                 | ,  |
|                    | Regist   | relf                     | JUL 1 2 20  | UU Z   | m K                   | Doge                              | 61                                 |                                     |  |                                  |                                 |  |

|  |                | For State   | State of Maryl  | and / Dep                              | artme                 |   | and Me                       | ental Hygi                           | ene                                 | le.                     | 22000  |
|--|----------------|---|---|--|-----------------------|---|------------------------------|--------------------------------------|-------------------------------------|-------------------------|--|
|  | -              | Registrar  1. Decedent's Name (First, Middle, Las                                       | · · · · · · · · · · · · · · · · · · ·   |  | lillica               | ile oi Deali                                    |                              | 2. Date of Death                     | g. No.                              | 10                      | 6.400  |
| Physic   | cian           |   | •   |  |                       |   |                              | Month                                | Day                                 | /ear                    | 3. Time of Death                                   |
| /Med   |                | Tammy Joanne Ecke   |   |  | T                     |   |                              | July 5                               | Ť                                   |                         | 3:30 P <sup>M</sup>                                |
| Exam   | iner           | 4a. Facility Name (If not institution, give   | street and number)  |  |                       | y, Town, or Location                            | of Death                     |                                      | 4c. County of                       | Death                   |  |
|  |                | 5500 Fishers Lane 5. Social Security Number 6. Se                                       | 7 400 (10.4   | em fant blieb de id                    | -                     | Rockville                                       | r 24 Hrs.                    |                                      | Mont                                |                         |  |
| Funera   |                |   | THE OFFICE  | rs. last birthday) 47 Yrs.             | Month                 |   | Min.                         | 8. Date of Birth<br>(Month, Day,     | Year)                               |                         | lace (State or Foreign<br>try)                     |
| Directo  |                | Usual Residence of Decedent   |   | 47                                     |                       |   | h                            | uly 31,                              | 1958                                | Mary                    | land   |
| land   | i              | 10a. State 10b. County  | 10c.  | City, Town or Lo                       | ocation               |   |                              |                                      |                                     | 10                      | Od. Inside City Limits                             |
| Many<br>feb  | ō              | Maryland Montgom  |   | D = -1-                                |                       | _   |                              |                                      |                                     |                         | 1 ☐ Yes 2 <u>1</u> ₹No                             |
| the 28a  | Directo        | Maryland Montgon  | iery  | Rock                                   |                       | e<br>Lip Code                                   |                              | 10                                   | g. Citizen of Wh                    | at Count                | 1-2  |
| be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel", or items 23s or 28s-f show event, the Modical Examinar must be notified as  | ā              |   |   |  | 101. 1                |   |                              | 10                                   | g. CRIZOTI OF WIT                   | iai Couri               | iry r  |
| eath   | Funeral        | 5500 Fishers Lane   | 12. Was Decedent Ever in  | 0115 12                                | Was Day               | 20852   | sisis? (Casa                 |                                      | United 14. Race                     |                         |  |
| ter d  | Ę              | 1 Never Married 25 Married  | Armed Forces? 1 ☐ Yes 2 ☒ No  | 10.3.                                  | If Yes, sp            | edent of Hispanic Or<br>ecify Cuban, Mexica     | in, Puerto R                 | ican, etc.)                          | Black,                              | White, e                | etc.   |
| hours af<br>urel', or  | by             | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates:  |  | 1 🗆 Yes               | 2⊠ No Specify                                   | <i>r</i> :                   |                                      | Specity:                            | Whi                     | te   |
| hou H  | e              |   |   | 16a Dece                               | dent's Lis            | ual Occupation                                  |                              |                                      | 6b. Kind of Busi                    | none/led                | lugate.  |
| within 72 hours after<br>ene.<br>then "naturel", or ite<br>he Wedical Examine  | Completed      | (Specify only highest grad  | le completed)   | (Give                                  | kind of v             | vork done during mo:<br>use retired)            | st of working                | 9 '                                  | OD. KING OF BUSI                    | nessymu                 | ustry  |
| withii<br>ene.<br>then   | Ē              | Elementary/Secondary (0-12)   | College (1-4or 5+)  | Dieta                                  |                       |   |                              |                                      | Geriati                             | cio (                   | Cara   |
| 12 should be filed within h and Mental Hygiene. 7 is marked other then "reumatic event, the Max  |                | 17. Father's Name (First, Middle, Last)   |   | Dicto                                  | <u> y .</u>           |   | er's Name                    | First, Middle, M                     | aiden Sumame)                       |                         | care   |
| d be file  | Be C           | Thomas E. Cole, S:  | -   |  |                       |   |                              |                                      | araon ozmano,                       |                         |  |
| d Me<br>mark   | မ              | 19a. Informant's Name/Relationship (T   |   | 10h Maili                              | Addes                 | SS (Street and Numb                             |                              | ummers                               | 0' T 0                              |                         | 0.11   |
| d 2 s<br>th an<br>th an<br>trau  |                | Charles Eckenrode   |   |  |                       |   |                              |                                      |                                     |                         | Code)  |
| Heat<br>ther   |                | 20a. Method of Disposition  |   | b. Place of Dispo                      |                       | ers lane,                                       |                              |                                      |                                     |                         | Chan   |
| or or o  |                | 1 ⊠ Burial 2 ☐ Cremation 3 ☐ F  | Removal from State  | cemetery, crei<br>Res                  | natory of             | other place)                                    | July Da                      |                                      | Oc. Location - Ci                   | ity or 10v              | wn, State  |
| tmer<br>tant   |                | 4 □ Donation 5 □ Other (Specify)  | 1 17  | lemorial                               | _Gar                  | dens  | 2006                         | 215                                  | ederick                             |                         |  |
| permit. Pages 1 and 2 should by Department of Health and Menta Important: if Item 27 is marked eny injury or other traumatic encours.  |                | 21. Signature of uparal Second Linears  | 90  | Res                                    | 2. Name<br>2. Stha    | and Address of Facili<br>Ven Funer              | al Se                        | rvices,                              | Skkot (                             | Codv                    | P.A.   |
| 40500  |                | 1//12/  | lications that caused the d   | 195                                    | 01 - 0                | atoctin M                                       | Itn. H                       | wy. Free                             | derick.                             | MD 2                    | 21701  |
| Physician / Medical / Medical / Medical / Asician and prival-itansit   |                | Immediate Cause (Final disease or condition resulting in death)                         | a. Spinal Corc  Due to (or as a cons  b. Non Small-C  Due to (or as a cons  Due to (or as a cons  c. Due to (or as a cons  Due to (or as a cons  Due to (or as a cons | d Compresequence of): Cell Car         | ssic                  | n   |                              |                                      |                                     | 2                       | Interval Batween Onset and Death 2 weeks 10 months |
| e be ex  | cai            |   |   |  |                       |   |                              |                                      |                                     |                         |  |
| cate<br>phys   |                |   | d   |  |                       |   |                              |                                      |                                     |                         |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown | 23c. If yes, outcome of pred<br>1 ☐ Live birth 2 ☐ F<br>4 ☐ Pregnant at time of<br>9 ☐ Unknown  | etal déath 3 [                         | Ectopic<br>Other (    | pregnancy<br>specify)                           |                              |                                      | 23d. Date of Month                  |                         | y<br>Day Year                                      |
| thet<br>ded b  | 4              | Part II. Other significant conditions co  | ntributing to death but not   | resulting in the u                     | nderlying             | cause given in Part I                           | 1.                           | 23e. Did toba                        | icco use contribi                   | ute to the              | cause of death?                                    |
| uires<br>sign  | d by           | Bi-Atrial Plexopa   |   |  |                       | _   |                              |                                      | _                                   |                         | .bly 4 □Unknown                                    |
| v requir<br>been si<br>should  | Completed      |   |   |  |                       |   |                              | -                                    |                                     |                         |  |
| e lav  | Ē              |   |   |  |                       |   |                              | 24a. Was an<br>autopsy               | pric                                | r to com                | sy findings available<br>pletion of cause of       |
| cate   | ပိ             |   |   | _                                      |                       |   |                              | performe<br>1 □ Yes 2x               |                                     | th?<br>Yes 2            | 2□ No  |
| Ciar<br>Sertif<br>Sector   | Be             | 25. Was case referred to medical examiner?  | Janaitat.   |  |                       | 1 -   | e of Death [                 | Check only one                       |                                     |                         |  |
| this aldir   | မ              | 1 163 2XX 110   | lospital:   |  |                       |   | ursing Home                  | 5 € Residen                          | ce 6 □Other                         | (Specify)               |  |
| ing F  | Ö              | 27. Manner of Death 1.   1.   1.   1.   1.   1.   1.   1.                               | 28a. Date of Injury<br>(Month, Day Year   | 28b. Time of<br>Injury                 |                       | 28c. Injury at<br>Work?                         | 28                           | d. Describe how                      | injury occurred                     |                         |  |
| eath<br>or: /  | cati           | 2 Accident investigation 3 Suicide 6 Could not be                                       |   |  | М                     | 1   Yes 2                                       | No                           |                                      |                                     |                         |  |
| tal or Att<br>rs efter d<br>al Direct<br>ed in by  | Certification: | 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury - A building, etc. (Spe  | t home, farm, str<br>ecify)            | eet, facto            | ry, office                                      | 28                           | f. Location (Stre<br>City or Town,   | et and Number<br>State)             | or Rurai                | Route Number,                                      |
| he Hospi<br>in 24 hou<br>he Funer<br>pletely fill  | edical         | 29a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medical Exami                    | sician: To the best of my a<br>ner: On the basis of exam<br>and manner stated.  | knowledge, death<br>ination and/or inv | occurre<br>vestigatio | d at the time, date an<br>n, in my opinion, dea | nd place, an<br>ath occurred | d due to the cau<br>at the time, dat | se(s) and manne<br>e and place, and | er as sta<br>I due to t | ted.<br>the cause(s)                               |
| To tl<br>withi<br>To tl  | ž              | 29b. Signature and title of certifier   |   | /                                      | 25                    | c. License number                               |                              | 290                                  | 1. Date signed (A                   | Month, D                | ay. Year)  |
| /  |                |   | Carl  | 31                                     | >                     | D 14626   | ·                            |                                      | July 7                              | 7. 20                   | 006  |
| n  |                | 30. Name and address of person who co   | ompleted cause of death (I  | tem 23a) (Type.                        | Print)                |   |                              |                                      |                                     | , -                     |  |
|  |                | Gregory P. Rausch,  |   |  |                       | t, Freder:                                      | ick, N                       | D 21701                              |                                     |                         |  |
| S  | ate            | 31. Date filed (Month, Day, Year)   |   |  |                       |   |                              |                                      |                                     |                         |  |
| Regist   | trar           | JUL 1 0 20  | JUD Jake  | gnature                                | and .                 | /   |                              |                                      |                                     |                         |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 1 tem 28b per me 9865 3-13-07 yt.
State of Maryland 7 Bepartment of Health and Mental Hygiene 2 0 0 5

1- State 7-6-06 Hegistrar Amend#'s27.& 28b.Per ME PCC cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Natala JuIy 3,Faudale 2006 1:00 AM /Medical 4a. Facility Name (If not institution, give street and number)
Prince George's Community Hospital **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Jay, Jan 7, **Funeral**  Birthplace (State or Foreign Country) Days None 1 ☐ M 2 💢 F 92 Director Italy Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Maryland Completed by Funeral Director Prince George's 1X Yes 2 No Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 9106 7th Street Items 23e 20706 Italy filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No 3₺ Widowed 4 Divorced Specify. Specify. "naturel". White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 17. Father's Name (First, Middle, Last) Unk permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth eny july or other traumatic event QREs. 18. Mother's Name (First, Middle, Maiden Sumame) Natala Celona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Giuseppe Faudale (Son) 9106 7th Street, Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify) Entombment Ft. Lincoln Cemetery 7/7/2006 Brentwood, MD 21. Signatus of Funeral Service License 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham, MD 20706 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nmediate Cause (Final Onset and Death HEMORRHAGE AFTER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 X No 1 Yes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check only one examiner? 1 Yes 2 □ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending luteral unknown investigation 7-1-06 1 Yes 2 No FALL DOWN 1 STAIRS 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide HOME 9106 FTG ST LANHAM MD 20106 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time date and place, and due to the cause(s) and manner as stated
and manner stated

290 Lineasa number. Medical (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL WILLIE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 6 2006

Registrar

| Physician   Phys   | 706  |       | Ple  | ase Type or Prin                        | it in Black I        | naelibie i                 | I <b>nk</b><br>tal Uvaiana                           |  |   |  |  |  |
|--|--|-------|--|---|----------------------|----------------------------|--|--|---|--|--|--|
| The company of the co | Fischer  |       |  | yland / Departme                        | ent of Health        | and Men                    |  | 00   | 00 0000   |  |  |  |
| Today Remet Arlon Fischer  Declaration of Declaration Control of Dec |  |       | enistrar   | Certifica                               | - Death              |                            |  |  | 3. Time of Death  |  |  |  |
| The Particle Name of Contractantian give states are no release.    Contractantian   Contract   Contractantian   Contractantia |  |       |  | ischer                                  |                      |                            | Month<br>July 4, 20                                  | Day Year<br>06                                 | 1617 hrs  |  |  |  |
| Social Searcy Version    Social Searcy Version   Socia |  |       |  |   | 4b. City, To         | wn, or Location            | of Death   |  |   |  |  |  |
| Substitute   Sub   |  |       | Dorchester General Hospital  |   | Cambr                | idge                       |  |  |   |  |  |  |
| Section   Sect   | Funeral  |       |  |   |                      |                            |  |  | roign   |  |  |  |
| The State of the S | Director   |       | 591-23-/395  | F 40                                    |                      | Dayo                       | reb.   | 19, 1966                                       | Country) Gallada  |  |  |  |
| Mary Land   Dorchester   Vicma   Too Sind and Number   Too Sind    | 8  |       |  | 10c City Town                           | or Location          |                            |  |  | 10d Inside City Limits  |  |  |  |
| The control of the co | w an   |       | · ·  | Too. Only, Town                         |                      | 2                          |  |  | 1 Yes 2 No  |  |  |  |
| The control of the co | yland<br>1-f sh  | 호     |  |   |                      |                            |  | 10g Citizen of What Country?                   |   |  |  |  |
| Solution of the control of the contr | or 28.   | ire   |  |   | 21                   | 1869                       |  | J  | JSA   |  |  |  |
| Solution of the control of the contr | vith th<br>s 23a<br>e noti   |       |  |   | 13. Was Decedent     | t of Hispanic Ori          | gin? ( Specify Yes or No                             |  |   |  |  |  |
| Solution of the control of the contr | eath v<br>item   | nue   | Never Married 2 2 Married  |   | If Yes, specify      | Cuban, Mexicar             | n, Puerto Rican, etc.)                               | White, et                                      |   |  |  |  |
| Some part of the p |  |       |  | е Үеаг                                  |                      |                            |  |  |   |  |  |  |
| Some part of the p | natura<br>Xami   |       |  |   |                      |                            |  | 16b. Kind of Busine                            | ess/Industry  |  |  |  |
| Some part of the p | uld be filed within 72 F<br>Mental Hygiene<br>marked other than "r<br>c event, the Medical E | olet  |  | ge (1-4 or 5+)                          | Sales                |                            |  | Wire Clo                                       | oth Manufactu   |  |  |  |
| Some part of the p | withi<br>giene<br>her th   | l w   |  |   |                      | 18.Mothe                   | er's Name (First, Middle,                            | Maiden Surname)                                | <del></del>   |  |  |  |
| Contact of Furth Proce Licensee   Contact of Furth Proce Licensee   Contact of Furth Process   Conta   | al Hyged of  |       |  | ner                                     |                      |                            | Carol A.   | Laturnus                                       |   |  |  |  |
| Contact of Furth Proce Licensee   Contact of Furth Proce Licensee   Contact of Furth Process   Conta   | Ment<br>Mark<br>mark   |       |  |   |                      |                            |  |  | State, Zip Code)  |  |  |  |
| Contact of Furth Proce Licensee   Contact of Furth Proce Licensee   Contact of Furth Process   Conta   | nd 2 shot<br>alth and<br>m 27 is<br>raumativ   |       | Deborah Fischer/Spou   |   |                      |                            |  |  | 0   |  |  |  |
| Contact of Furth Proce Licensee   Contact of Furth Proce Licensee   Contact of Furth Process   Conta   | l and<br>Heal<br>Fitem   | - 13  |  | cremati                                 | ory or other place)  |                            |  |  |   |  |  |  |
| Continued of Cause of Continued Cause of Cause   | Pages<br>lent of<br>inf:   |       | 4 Densting 5 Other Specific  | Miasho                                  |                      |                            |  |  |   |  |  |  |
| Page and Letter the displace or conditions or conditions and class on each file.    Page   File   Letter the displace or conditions or conditions   Secure   Letter   | mit.<br>partin   |       | ignature of Funer // ervice Licensee   |   | 22. Name and A       | Address of Facil<br>Bromwe | 1 Funeral  | Home, P.A.                                     |   |  |  |  |
| The control of the    | 1 ៩០៩៩   | 1     | bleestitures 12  | mucel                                   | 308 His              | h <u>St.,</u>              | Cambridge,   | MD 2161  | Approximate Interva   |  |  |  |
| Transcription of the property  |  |       | tailure List only one cause on each line.  |   |                      |                            |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate course from Underlying Cause. Enert Underlying Cause (Disease or injury that initiated events resulting in death). Last    Due to (or as a consequence of):   | ;<br>Examiner  |       |  |   | sclerotic o          | cardiovaso                 | cular disease  | complicated                                    | by hypertherma  |  |  |  |
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| The purpose of the pu | e e  | ical  | XUNPENDED AMEN   | DED item#23a,27,                        | 28a-f,perM           | E,g857,7/2                 | 26/06 TT   |  |   |  |  |  |
| The purpose of the pu | ate be<br>shysic<br>ne bur   | Mec   |  | yes, outcome of pregnancy               |                      |                            |  |  |   |  |  |  |
| The purpose of the pu | ertific<br>ding p  | ian/  | nast 12 months?  | D                                       |                      |                            | oic pregnancy  | Month  | Day Year  |  |  |  |
| The purpose of the pu | eath c<br>atten<br>for us  | Sic   | 4 The office of the leaves The   | -                                       | 5 Other (Spec        | erry)                      |  |  |   |  |  |  |
| 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Month, Day, Year) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to th | t the d  | E     | Part II. Other significant conditions contribu   | ting to death but not resulting         | ng in the underlying | cause given in l           | Part I 23e Did                                       | tobacco use contribu                           | te to the cause of death?                                     |  |  |  |
| 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Month, Day, Year) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to th | es that<br>igned   | À     |  |   |                      |                            | 1Y   | es 2 No 3                                      | Probably 4  Unknown   |  |  |  |
| 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Month, Day, Year) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to th | requir<br>been s   | ete   |  |   |                      |                            |  | s an 24b. We                                   | re autopsy findings available<br>or to completion of cause of |  |  |  |
| 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Month, Day, Year) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to th | e law<br>e has<br>e has  | Ē     |  |   |                      |                            |  |  |   |  |  |  |
| 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the  | n: Th<br>tifficat<br>or, pay   | ြိ    | 25. Was case referred to medical   |   |                      |                            |  |  |   |  |  |  |
| 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the  | ysicia<br>ysicia<br>ysicia<br>ysicia<br>direct   | o Be  | Tioopital.   | Inpatient 2 V ER/C                      | Outpatient 3 D       | DA Other <sub>4</sub>      | Nursing Home 5                                       | Residence 6                                    | Other   |  |  |  |
| 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. July 5, 2006  30. Name and address of person who complete cause of death (Item 23a)  The Doro Find (Month, Day, Year) 32. Revertical Signature and address of person who complete cause of death (Item 23a) and manner as started at the time, date and place, and due to the cause(s) and manner as started (Month, Day, Year) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as tarted at the time, date and place, and due to the cause(s) and manner as tarted at the time, date and place, and due to the cause(s) and manner as tarted at the time, date and place, and due to the cause(s) and manner as tarted at the time, date and place, and due to the cause(s) and and the time, date and place, and due to the cause(s) and due to the  | ig Phy<br>ifter the  | -     |  |   | Time of Injury 2     |                            |  | e how injury occurred                          |   |  |  |  |
| 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. July 5, 2006  30. Name and address of person who complete cause of death (Item 23a)  The Doro Find (Month, Day, Year) 32. Revertical Signature and address of person who complete cause of death (Item 23a) and manner as started at the time, date and place, and due to the cause(s) and manner as started (Month, Day, Year) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as tarted at the time, date and place, and due to the cause(s) and manner as tarted at the time, date and place, and due to the cause(s) and manner as tarted at the time, date and place, and due to the cause(s) and manner as tarted at the time, date and place, and due to the cause(s) and and the time, date and place, and due to the cause(s) and due to the  | ath<br>Or: A   | io    | o reliaing   |   | ık                   | 1 Yes 2                    | t distance.  | and the second second                          |   |  |  |  |
| 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as started (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. July 5, 2006  30. Name and address of person who complete cause of death (Item 23a)  The Doro Find (Month, Day, Year) 32. Revertical Signature and address of person who complete cause of death (Item 23a) and manner as started at the time, date and place, and due to the cause(s) and manner as started (Month, Day, Year) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as started at the time, date and place, and due to the cause(s) and manner as tarted at the time, date and place, and due to the cause(s) and manner as tarted at the time, date and place, and due to the cause(s) and manner as tarted at the time, date and place, and due to the cause(s) and manner as tarted at the time, date and place, and due to the cause(s) and and the time, date and place, and due to the cause(s) and due to the  | or Att<br>frer de<br>Direct  | ilic  | 286  |   |                      | office building,           | etc. 28f. Location                                   | (Street and Number<br>State) 119 Wat           | or Rural Route Number, Cit<br>CET Street                      |  |  |  |
| 296 Signature and title of certifier  O.C.M.E.  July 5, 2006  30 Name and address of person who completed cause of death (Item 23a)  The Dore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201   | pital ours a   | le l  | 4 Homicide determined (S)  |   |                      |                            | Vienna,  | , MD   |   |  |  |  |
| 296 Signature and title of certifier  O.C.M.E.  July 5, 2006  30 Name and address of person who complete cause of death (Item 23a)  The Dore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  | e Hos<br>1 24 h<br>e Fun   |       | (Orrotal any   | he best of my knowledge, de             | eath occurred at the | time, date and             | place, and due to the ca<br>occurred at the time. da | iuse(s) and manner at<br>te and place, and due | s started<br>e to the cause(s)                                |  |  |  |
| 296 Signature and title of certifier  O.C.M.E.  July 5, 2006  30 Name and address of person who complete cause of death (Item 23a)  The Dore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  | To th<br>withir<br>To th   | ledic | and ma   | nner stated                             |                      |                            |  |  |   |  |  |  |
| 30 Name and address of person who complete cause of death (Item 23a)  The Dore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  |  | 2     | 290 Signature and title of certifier   | -                                       | 250                  |                            |  |  |   |  |  |  |
| Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  | 1  |       | Theodor M. Ky  | y _ w                                   |                      |                            |  |  |   |  |  |  |
| 24 Detailed (March Day Yood) 32 Redistrar's Signature  | ,  |       | The state of the s |   |                      | et, Baltimor               | e, MD 21201  |  |   |  |  |  |
|  |  | 25-1  | 24 Data filed (Marth Day Vaar)   | 32 Redistrar's Signature -              |                      | ,                          |  |  |   |  |  |  |
| Registrar  | ~  |       |  |   |                      |                            |  |  |   |  |  |  |

|                |   |                | For<br>State<br>Registrer  | State of Mary  | _                                    | artment of He<br>rtificate of D              |                     | Re                              | ig. No.   | 6 22993  |  |  |  |  |
|----------------|---|----------------|--|--|--------------------------------------|--|---------------------|---------------------------------|---|--|--|--|--|--|
|                | Physicia  | an             | 1. Decedent's Name (First, Middle, Las   | •  |                                      |  |                     | 2. Date of Death<br>Month       | Day Y   | 3. Time of Death   |  |  |  |  |
|                | /Medic  | al             | Robert   | S.   |                                      | Fuss   |                     | June                            | 30 200  |  |  |  |  |  |
| 1              | Examin  | er             | 4a. Facility Name (If not institution, give<br>Heritage Harbour  |  | hah                                  | 4b. City, Town, or I                         |                     |                                 | 4c. County of   | rundel   |  |  |  |  |
| _              | Francis   |                | 5. Social Security Number 6. Se  |  | yrs. last birthday)                  | If Under 1 Year                              | If Under 24 Hrs.    | 8. Date of Birth                |   | ). Birthplace (State or Foreign<br>Country)                      |  |  |  |  |
|                | Funeral<br>Director   |                | 218-07-7180  | <u>TX</u> M 2□ F 8   | 9 Yrs.                               | Months Days                                  | Hours Min.          | (Month, Day,<br>Sept. 25        | 5,1916  | Maryland   |  |  |  |  |
|                | p   |                | Usual Residence of Decedent  10a. State 10b. County  | 10   | c. City, Town or Lo                  | ncation                                      |                     |                                 |   | 10d. Inside City Limits  |  |  |  |  |
|                | faryta<br>  •hov  | 5              | MD Anne Ar   |  | Dea                                  |  |                     |                                 |   | 1 ☐ Yes 2 ☐ No   |  |  |  |  |
|                | 28a-  | Director       | 10e. Street and Number   |  | 500                                  | 10f. Zip Code                                |                     | 10                              | 0g. Citizen of Wh   |  |  |  |  |  |
|                | 3a or   | 0              | 618 Clark Avenue,  | P.O. Box 8   | 1                                    | 2075   | 1                   |                                 | USA   |  |  |  |  |  |
|                | death   | ner            | 11. Marital Status   | 12. Was Decedent Ever<br>Armed Forces?   |                                      | Was Decedent of His<br>If Yes, specify Cuban |                     | ecify Yes or No-                | 14. Race -  | American Indian,<br>White, etc.                                  |  |  |  |  |
| 21215-0036     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or items 23s or 28s-f show say injury or other traumatic event, in Medical Exactional terminal termination. | by Funeral     | 1 Never Married 2 Married  3XXWidowed 4 Divorced   | 1 XYes 2 No<br>If Yes, Give<br>Year or Dates: 19   |                                      | 1□Yes XXNo                                   | Specify:            | ,                               | Specify:  | White  |  |  |  |  |
| 5-0            | 72 ho   | Completed      | 15. Decedent's Ed<br>(Specify only highest grad  | ucation<br>de completed)   | (Give                                | dent's Usual Occupa<br>kind of work done do  | uring most of work  | ing                             | 16b. Kind of Busin  | ness/Industry  |  |  |  |  |
| 7              | Man a   | d<br>d         | Elementary/Secondary (0-12)  | College (1-4or 5+)   | life.                                | DO NOT use retired) tenance                  |                     |                                 | Giant   | Food   |  |  |  |  |
|                | Hygie<br>Hygie<br>ther t<br>nt, in  | ပိ             | 17. Father's Name (First, Middle, Last)  |  | riain                                |  | 18. Mother's Name   | e (First, Middle, N             |   |  |  |  |  |  |
| aŭ             | d be<br>Bental<br>Ked o   | To Be          | Ottis A. Fuss  |  |                                      |  | Jessie H            |                                 |   |  |  |  |  |  |
| Maryland       | shou<br>and M<br>mer<br>umat  | -              | 19a. Informant's Name/Relationship (7  | уре, Print)  | 19b. Maili                           | ng Address (Street a                         | nd Number or Rur    | al Route Number,                | City or Town, St  | ate, Zip Code)   |  |  |  |  |
|                | and 2<br>belth a<br>27 is   |                | Robert McCeney (S  |  |                                      | Clark Ave                                    |                     |                                 |   |  |  |  |  |  |
| ore            | of He<br>of He<br>if item<br>or oth   |                | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐  |  | Ob. Place of Dispo<br>cemetery, crea | osition (Name of<br>matory or other place    | )                   | Date 2                          | 20c. Location - Ci  | ty or Town, State  |  |  |  |  |
| Ë              | Pag<br>tment<br>tant:   |                | 4 □Donation 5 □ Other (Specify   | )  |                                      | Mem. Gdns                                    |                     | 2006                            | Davidso   | nville, MD   |  |  |  |  |
| Baltimore,     | Depermit<br>Deper<br>Impor<br>eny in  |                | 21. Signature of Funeral Service Light   | <b>%</b>   | 22                                   | 2. Name and Address<br>Hardesty<br>12 Ridge  | Funeral<br>1y Avenu | Home, P<br>e, Annap             | .A.<br>olis. MD   | 21401  |  |  |  |  |
|                |   |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.  Approximate Interval Between Onset and Death |  |                                      |  |                     |                                 |   |  |  |  |  |  |
|                | Physician<br>/Medical<br>Examiner   |                | Immediate Cause (Final disease or condition  | a Ctech  | Luoma                                | - prost                                      | rele                |                                 |   | Onset and Death  |  |  |  |  |
|                |   |                | resulting in death)  | Due to (or as a co   | insequence of):                      | L 17   | VIIO.               |                                 |   |  |  |  |  |  |
|                |   | -0             | Sequentially list conditions, if any, leading to immediate   | b. Due to (or as a co  | insequence of):                      | te   | ~/~~                |                                 |   |  |  |  |  |  |
|                | uted<br>d<br>ansit  | Examiner       | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events   | . Deul   | کی (                                 |  |                     |                                 |   |  |  |  |  |  |
| oʻ             | exec<br>en en<br>rrial-tr   | Exa            | resulting in death) Last   | Due to (or as a co   | nsequence of):                       |  |                     |                                 |   |  |  |  |  |  |
| 8760,          | cate be executed<br>physicien end<br>s the burial-transit   | dicai          |  | d  |                                      |  |                     |                                 |   |  |  |  |  |  |
| Φ              |   | Med            | IF FEMALE:   | 23c. If yes, outcome of p  | ragnancu                             |  |                     |                                 |   |  |  |  |  |  |
| Вох            | it the death certifi<br>by the attending<br>tached for use as   | Physician/Me   | in the past 12 months?   | 1 Live birth 2 □   | Fetal death 3                        | Ectopic pregnancy Other (specify)            |                     |                                 | 23d. Date of Month  |  |  |  |  |  |
| o.             |   | nysi           | 1 Yes 2 No<br>9 Unknown  | 9 Unknown  |                                      |  |                     |                                 |   |  |  |  |  |  |
| ď              | The law requires that the site has been signed by the bage 2 should be detache  | by PI          | Part II. Other significant conditions or   | ontributing to death but no  | ot resulting in the u                | inderlying cause give                        | n in Part I.        | 23e. Did tob                    | acco use contrib  | ute to the cause of death?                                       |  |  |  |  |
| rds            | v require<br>been sig<br>should b   | Pa             |  |  |                                      |  |                     | 1 □ Ye                          | s 2 □ No 3  | Probably 4 Unknown   |  |  |  |  |
| Vital Records, | e law re<br>has be<br>je 2 sho  | Completed      |  |  |                                      |  |                     | 24a. Was ar<br>autops           | n 24b. We   | ore autopsy findings available or to completion of cause of ath? |  |  |  |  |
| <u> </u>       |   | So             |  |  |                                      |  |                     | perform                         | ned? dea  | ath?<br>] Yes 2 □ No   |  |  |  |  |
| Vita           | Physician: The this certificate ral director, pag   | Be             | 25. Was case referred to medical examiner?   | Hospital:  |                                      | Othe   | 26. Place of Deat   |                                 |   |  |  |  |  |  |
|                |   | . To           | 1 Yes 2 No 27. Manner of Death   | 28a. Date of Injury  | 2 ER/Outpaties                       | nt 3L DOA                                    | Nursing Ho          | me 5 Reside<br>28d. Describe ho |   |  |  |  |  |  |
| on             | Attending Ph r death.  sctor: After thing the funeral   | tio            | Natural 5 Pending 2 Accident investigation   | (Month, Day Ye   | ar) Injury                           |  | ?<br>'es 2 \_No     |                                 |   |  |  |  |  |  |
| Division of    | a the second  | Certification: | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of Injury<br>building, etc. (5  | At home, farm, st                    | reet, factory, office                        |                     |                                 | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |  |  |  |  |  |
|                | To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by  | edical C       |  | ysician: To the best of m<br>kiner: On the basis of exa<br>and manner stated   | amination and/or in                  |  |                     |                                 |   |  |  |  |  |  |
|                | thin ;<br>o the   | Med            | 29b. Signature and title of certifier  | And manial states  |                                      | 29c. License                                 | number              | 29                              | 9d. Date signed (   | Month, Day, Year)  |  |  |  |  |
|                | P 5 P 0   |                | <b>)</b> (/ <u>)</u> )   |  |                                      | DE   | 7008                | 3                               | 010-3   | 20-17  |  |  |  |  |
|                |   |                | 30. Name and addre of person who   | completed cause of death   | ı (İtem 23a) (Type,                  | , Print)                                     | Salat               | ERIAN                           |   | mo siuni   |  |  |  |  |
|                | Sta<br>Regist   | ate<br>rar     | 31. Date filed (Month, Day, Year)  JUL 0 5   | 32. A gistrar's  | Signature                            | had o  | mittell 1 fee?      | X                               |   |  |  |  |  |  |
|                | negist  |                | JOE 0 0  | The state of the s | - 10                                 |  |                     |                                 |   |  |  |  |  |  |

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death Day **Physician** JULY 2006 JAMES MILTON FAULKNER 11:35PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CAROLINE DENTON CAROLINE NURSING HOME 5. Social Security Number 6. Sex 1**X** M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Days 89 220-34-9650 Director MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f show ed other than "naturel", or items 23a or 28e-f showers, the Medical Evantres must be notified at Director 1▼ Yes 2 No DENTON CAROLINE MD the 10e. Street and Number 10f. Zip Code 10g. Cilizen of What Country? with 21629 USA 520 KERR AVE. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. While, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. Iem 27 is marked other than Elementary/Secondary (0-12) FARMER AGRICULTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ELLA STARKEY EDGAR T.FAULKNER other treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Importent: If Item 27 is
any injury or other treu 6246 LANDING NECK ROAD, EASTON, MD 21601 JAMES T. FAULKNER/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Aurial 2 Cremation 3 Removal from State GREENMOUNT CEMETERY 7/12/2006 HILLSBORO, MARYLAND ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Ju CSTROUGH Jaseg 4 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events could be act to the cause of th Examiner Due to (or as a consequence of). use as the burial-transit and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. ed by the attending physician detached for use as the buria 99 Physician/Medicai IF FFMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown n signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. à 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 1 Yes 2 000 Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes No 10 2 ER/Outpatient 3□ DOA 4 ursing Home 5 Residence el or Attending Physical States death.

Joint Director: After this ad in by the funeral d 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Accident Division 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Washington 0 31. Date filed (Month, Da r's Signature State Registrar

# Amend item #20b, per FH, SL 07/06/06 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |   |                  | For   |                      | Marylan                          |                            |  |                   |             |             | •                                       | giene         | ~ ~ ~                         | 2200                            |
|---------------------|---|------------------|---|----------------------|----------------------------------|----------------------------|--|-------------------|-------------|-------------|---|---------------|-------------------------------|---------------------------------|
|                     |   |                  | For<br>State<br>Registrar   |                      |                                  | Ce                         | rtificate                              | e of L            | Death       |             |   | leg. No.      | UUb                           | 55330                           |
| П                   | Physicia  |                  | Decedent's Name (First, Middle,   | Last)                |                                  |                            |  |                   |             |             | <ol><li>Date of Dea<br/>Month</li></ol> | Day           | Year                          | 3. Time of Death                |
|                     | /Medic  | al               | Pamela (factor)   | Marie                | -41                              | Fox_                       | 4h City                                | Tour or           | Location of | of Death    | June_                                   |               | 2006<br>County of Deat        | 1045 AM M                       |
|                     | Examin  | er               | 4a. Facility Name (If not institution,  |                      |                                  |                            | ,                                      |                   | ss An       |             |   |               | nerset                        |                                 |
|                     | Funeral   |                  | 33109 West Pos  5. Social Security Number   | 6. Sex 1.            | 7. Age (In yrs.                  | last birthday)             | If Under                               | 1 Year            | If Under    |             | 8. Date of Birt<br>(Month, Da)          |               | 9. Birt                       | hplace (State or Foreign        |
|                     | Director  |                  | 216-72-2772   | 1□M 2AF              | 48                               | Yrs.                       | Months                                 | Days              | Hours       | Min.        | 02-12-                                  |               | 1                             | yland                           |
|                     | pu ,  |                  | Usual Residence of Decedent  10a, State 10b, County   |                      | 10c Cit                          | y, Town or Lo              | ocation                                |                   |             |             |   |               |                               | 10d. Inside City Limits         |
|                     | laryla<br>ehov  | ក                | Toa. State Tob. County  |                      |                                  |                            |  |                   |             |             |   |               |                               | 1 ☐ Yes 2 No                    |
|                     | the N   | ect              | MD Somers  10e. Street and Number   | et                   | Pri                              | ncess                      | Anne<br>10f. Zip                       | Code              |             |             |   | 10g. Citiz    | en of What Co                 | untry?                          |
|                     | Mith<br>Ba or   | Funeral Director | 33109 West Pos  | t Office             | Road                             |                            |  | 2185              | 53          |             |   |               | USA                           |                                 |
|                     | death   | era              | 11. Marital Status  |                      | dent Ever in U                   | .S. 13.                    | Was Deced                              |                   |             | gin? (Spe   | cify Yes or No-<br>Rican, etc.)         | 1             | 4. Race - Ame<br>Black, White |                                 |
| 9                   | or Ite  | 교                | 1 Never Married 2 Marrie  |                      | 2 No                             |                            | 1 ☐ Yes                                | 8 /               | Specify:    |             | iloan, etc./                            |               | Specify:                      | e, etc.                         |
| ဗ္ဗ                 | ural',  | d by             | 3 Widowed 4 Divorced  | Year or Da           | ates:                            |                            |  |                   |             |             |   |               | W                             | hite                            |
| Maryland 21215-0036 | within 72 hours after death with the Maryland<br>ene.<br>then "natural", or iteme 23a or 28e-f ehow<br>the Medical Exam incrinust be notified at  | Completed        | 15. Decedent<br>(Specify only highes  |                      |                                  | (Give                      | dent's Usua<br>kind of wo<br>DO NOT us | rk done c         | lurina mos  | t of workin | lg                                      | 100. Kin      | d of Business/                | industry                        |
| 12                  | withii<br>ene.<br>then  | шо               | Elementary/Secondary (0-12) 11  | College (1           | -4or 5+)                         | Hot                        | ısewif                                 | 6                 |             |             |   | Own           | Home                          |                                 |
| b                   | e filed within<br>al Hygiene.<br>I other then<br>vant, the Ms   | Be C             | 17. Father's Name (First, Middle, L   |                      |                                  | 11.00                      |  |                   | 18. Mothe   | er's Name   | (First, Middle,                         |               |                               |                                 |
| <u>la</u> r         | Mental<br>Mental<br>arked c   | To B             | Hugh Brian Mu   | llican, S            | r.                               |                            |  |                   | Edn         | a Low       | re                                      |               |                               |                                 |
| lar)                | 2 should and Men ls marke raumetic  |                  | 19a. Informant's Name/Relationsh  |                      |                                  |                            | •                                      |                   |             |             |   |               | Town, State, 2                | Zip Code)                       |
|                     | s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other then "natural", or Iteme 23s or 28e-f show other traumetic evant. The Medical Exam are must be notified at |                  | Edna Lowe Mull  | ican/Moth            |                                  |                            |  |                   | -           |             | verly,                                  |               | 37185<br>cation - City or     | Town State                      |
| Baltimore,          | Pages 1<br>nent of H<br>int: If ite<br>iry or ot  |                  | 20a. Method of Disposition 1 □ Burial 2 🗵 Cremation   | 3 Removal from       | State                            | Place of Disponentery, cre |  |                   | - 1         | 07/03       |   |               |                               |                                 |
| Ē                   | it. Pa<br>intmen<br>intant:<br>njury  |                  | * 4 □ Donation 5 □ Other (Sp  |                      | \ Sε                             | ılisbuı<br>2               | ry Cre<br>2. Name an                   |                   |             |             | 1706-                                   | Sal           | isbury,                       | MD                              |
| Ba                  | permit. Pages 1<br>Department of H<br>Important: If ite<br>any injury or ot<br>once.  |                  | horan LOVa  | 1 Nes (              | ]<br>1 MOO29                     | H                          | Lnman                                  | Fune              | eral        | Ĥome        | Prince                                  | 200 /         | Anna M                        | D 21853                         |
|                     |   |                  | 23a. Part1. Enter the disease, or   | complications that   | aused the deat                   |                            |  |                   |             |             |   |               | Airie , II                    | Approximate<br>Interval Between |
|                     | Physician   |                  | shock, or heart failure. List<br>Immediate Cause (Final   | only one cause on e  | acrime.                          | Smia                       | A:                                     | 0.0               | (090        | Car         | A A000 A0                               |               |                               | Onset and Death                 |
|                     | /Medical  |                  | disease or condition resulting in death)  | Due to               | or as a consec                   | quence of):                |  | n m               | 11 10       | mar         | Aum                                     | 7             |                               | 1772                            |
| н                   | Examiner  |                  | Sequentially list conditions  | b                    |                                  |                            | ( , , , , ,                            |                   | 1 *         |             |   | `             |                               |                                 |
|                     | p tig   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to               | (or as a consec                  | quence of):                |  |                   |             |             |   |               |                               |                                 |
|                     | and II-tran   | xam              | that initiated events<br>resulting in death) Last   | c                    | (or as a consec                  | quence of):                |  |                   |             |             |   |               |                               |                                 |
| 760,                | be executed<br>sician and<br>burial-transit   | caiE             |   |                      |                                  |                            |  |                   |             |             |   |               |                               |                                 |
| 687                 | leath certificate b<br>attending physic<br>I for use as the b   |                  |   | Q                    |                                  |                            |  |                   |             |             |   |               |                               |                                 |
| Box                 | n certi   | N/M              | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, out     | tcome of pregn                   |                            | ⊒Ectopic p                             | regnancy          | ,           |             |   | 2             | 3d. Date of de                |                                 |
|                     | that the death<br>ned by the atter<br>detached for u  | Physician/Med    | in the past 12 months?<br>1 □ Yes 2 No  |                      | ant at time of o                 |                            | Other (sp                              |                   |             |             |   |               | Month                         | Day Year                        |
| P.0                 | at the<br>by the  | Phys             | 9 Unknown   |                      |                                  |                            |  |                   | - in Don't  |             | 23a Did t                               | obacco III    | eo contributo tr              | the cause of death?             |
|                     | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit  | by               | Part II. Other significant condition  | ns contributing to a | eath but not res                 | suiting in the i           | underiying c                           | ause giv          | en in Parti | 1.          |   | Yes 2         |                               | robably 4 Onknown               |
| Records,            | v requires<br>been sign<br>should be  | Completed        |   |                      |                                  |                            |  |                   |             |             | 24a. Was                                |               |                               | utopsy findings available       |
| 3ec                 | eician: The law<br>certificate has t<br>irector, page 2 s   | m<br>jd<br>m     |   |                      |                                  |                            |  |                   |             |             | autor<br>perfo                          | osy<br>irmed? | prior to death?               | completion of cause of          |
| la                  |   |                  | 25. Was case referred to medical  |                      |                                  |                            |  |                   | 26 Place    | e of Death  | 1 ☐ Yes                                 | 200 No        | 1 Yes                         | ; 2□ No                         |
| Vital               | Physician:<br>r this certific<br>ral director,  | o Be             | examiner?<br>1 ☐ Yes 2 🕱 No   | Hospital: 1 🗆        | Inpatient 2                      | ] ER/Outpatie              | ont 3 🗆 D0                             | Oth               |             | ursing Hor  | 1                                       |               | i □Other (Spe                 | cify)                           |
| 10                  | ding Phy<br>After thi<br>funeral  | n: T             | 27. Manner of Death 1 XNatural 5 ☐ Pendin   | 28a. Date<br>(Mon    | of Injury<br>th, Day Year)       | 28b. Time                  | of :                                   | 28c. Injur<br>Wor | y at<br>k?  | 2           | 28d. Describe                           | how injury    | occurred                      |                                 |
| sior                | Attending in death.   | atic             | 2 Accident investig   | pation               |                                  |                            | М                                      | _                 | Yes 2       | -           |   |               |                               |                                 |
| Division of         | or Att<br>after de<br>Direct<br>in by t   | Certification:   | 3 Suicide 6 Could I 4 Homicide determ   | 259. Place           | of Injury - At hing, etc. (Speci | nome, farm, s<br>ify)      | treet, factor                          | y, office         |             | 1           | City or To                              |               |                               | ural Route Number,              |
|                     | Hoepital of hours a Funeral C   |                  | 29a. Certifier 1 Certifyin  | g Physician: To the  | a hest of my kn                  | owledne dea                | th occurred                            |                   | ne. date a  | nd place. a | and due to the                          | cause(s)      | and manner as                 | s stated.                       |
|                     | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral   | Medical          | (Check only 2 Medical one)  | Examiner: On the b   | asis of examin<br>iner stated.   | ation and/or i             | nvestigation                           | n, in my o        | pinion, de  | ath occurre | ed at the time,                         | date and      | place, and due                | e to the cause(s)               |
|                     | To the within 2 To the comple   | Me               | 29b. Signature and title of certifie  |                      | ,////                            |                            | 29                                     | c. Licens         | e number    |             |   | 29d. Date     | signed (Mont                  | th, Day, Year)                  |
|                     |   |                  | 1/10  | vono.                | 1110                             |                            |  | 121               | 050         | )           |   | 7/            | 1/86                          |                                 |
|                     |   |                  | 30. Name and address pers   |                      |                                  | m 23a) (Type               | , Print)                               | 1 10 0            |             |             | Carrie                                  |               | ~                             | m                               |
|                     |   |                  | Joseph W.   | (MASSI               | D [V]                            | J E                        | (.V                                    | MUR U             | il J        | T.          | SIMISI                                  | sun           | y                             | N                               |
|                     | St<br>Regist  | ate<br>rar       | 31. Date filed (Month, Day, Year)   |                      | Registar's Sign                  | ature                      | bee                                    | K                 |             |             |   |               |                               |                                 |
|                     |   |                  | 001   | 0                    |                                  |                            | 1                                      |                   |             |             |   |               |                               |                                 |

State of Maryland / Department of Health and Mental Hygiene

|            |   |                                       |   |                                 |                    |                  | Certifica        | te of            | Death                                     | ,                  | Reg. No   | ZUL          | 16                  | 22                       | 990        |
|------------|---|---------------------------------------|---|---------------------------------|--------------------|------------------|------------------|------------------|---|--------------------|-----------|--------------|---------------------|--------------------------|------------|
| Ш          | Develois  |                                       | 1. Decedent's Name (First, Middle, La   |                                 |                    |                  |                  |                  |   | 2. Date of De      | eth       |              |                     | 3. Time                  | of Death   |
| 200        | Physicia<br>/Medica   |                                       | Catharine Schnebl   | y Fockle:                       | r                  |                  |                  |                  |   | July               | l, De     | ,<br>2006 )  | /ear                | 11:55                    | 5 AM       |
|            | Examine   |                                       | 4a Fecility Name (If not institution, giv   |                                 | r)                 |                  |                  |                  | 4b. City, Town, or                        | Location of Deel   | h 4c      | . County of  | Death               |                          |            |
|            |   | В                                     | Solomons Nursing  | Center                          |                    |                  |                  |                  | Solomo                                    | ns                 |           | Ca1          | vert                |                          |            |
|            | Funeral   |                                       | 5. Social Security Number 6. S  |                                 | Age (In yrs.       |                  | day) If Unde     | r 1 Year<br>Days |   |                    | rth       |              |                     |                          | or Foreign |
|            | Director  |                                       | 176-26-1729   | I□M 285F                        | 96                 | Y                | rs.              | Days             | Hours Min                                 | Jan. 9             |           | 10           |                     | y1and                    |            |
|            | p ,   |                                       | Usuel Residence of Decedent   |                                 | 1                  |                  |                  |                  |   |                    |           |              |                     |                          |            |
|            | aryla<br>shov   | _                                     | 10a. Stete 10b. County  |                                 | 10c. Ci            | y, Town          | or Location      |                  |   |                    |           |              | 10                  | od. Inside (             |            |
|            | 8 A   | 잃                                     | Maryland Calver   | rt                              | S                  | olom             | ons              |                  |   |                    |           |              |                     | 1 🗌 Ye                   | s 2⊠No     |
|            | ith th  |                                       | 10e. Street end Number  |                                 |                    |                  | 10f. Zi          | p Code           |   |                    | 10g. Cit  | tizen of Wh  | et Count            | гу?                      |            |
|            | 23 s  | Funeral Director                      | 13325 Dowell Road   |                                 |                    |                  |                  | 206              | 88  |                    | Ū         | nited        | Sta                 | ites                     |            |
|            | ep de   | - P                                   | 11. Marital Status  | 12. Was Deceder<br>Armed Forces | nt Ever in U<br>s? | ,S.              | 13. Was Dece     | dent of          | Hispanic Origin? (S<br>pan, Mexican, Puer | Specify Yes or No  | >-        | 14. Race -   | America<br>White, e |                          |            |
| 2          |   |                                       | 1 ☐ Never Married 2 ☐ Married   | 1 ☐ Yes 2 Ē<br>If Yes, Give     |                    |                  | 1□ Yes           |                  |   |                    |           | Specify:     |                     | ite                      |            |
| 15-0020    | nuod nuod   | Ď                                     | 3 ☑ Widowed 4 □ Divorced Year or Dates:   |                                 |                    |                  |                  |                  |   |                    |           | орвену.      | WII                 | rre                      |            |
| ប៉         | nat   | Completed                             | 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of will fee. DO NOT use retired) |                                 |                    |                  |                  |                  |   | rking              | 16b. K    | ind of Busi  | ness/Ind            | ustry                    |            |
| 7          | ha ithi.  | E                                     | Elementery/Secondary (0-12)   | College (1-4o<br>5+             | r 5+)              |                  |                  |                  | od)                                       |                    |           |              |                     |                          |            |
|            | at Hygie<br>other t   | ပိ                                    | 17. Fether's Name (First, Middle, Last)   |                                 |                    |                  | Teache           | r                | T   | <del></del>        |           |              |                     | Educa                    | tion       |
| yland      | lid be f<br>lental !<br>ked of<br>ic eve  | e e                                   |   |                                 |                    |                  |                  |                  |   | me (First, Middle  | , Maiden  | Sumame)      |                     |                          |            |
| Γ'         | should<br>ind Men<br>imarke<br>umatic   | <u></u>                               | Lewis Aılen Schne   |                                 |                    |                  |                  |                  | Clara M                                   |                    |           |              |                     |                          |            |
| =          |   |                                       | 19e. Informant's Neme/Relationship (  |                                 |                    |                  |                  |                  | and Number or R                           |                    |           |              | ate, Zip            | Code)                    |            |
|            | 1 and<br>Haalth<br>IM 27<br>Iher to   | -                                     | Jane Messersmith  20e. Method of Disposition  | / Daugnte                       |                    |                  | Disposition (Na  |                  | Tall Ti                                   |                    |           |              |                     |                          |            |
| ច្ច        | Pages 1 an<br>ment of Haal<br>lant: If Item 2<br>jury or other  |                                       | 1 ☐ Burial 2 ☐ Cremetion 3 ☐  | Removal from Stat               | e _ c              | emetery          | crematory or     | other pla        |   | July 7,            | 20c. Lo   | ocation - Ci | ty or Tov           | m, State                 |            |
|            | tmer<br>tant:   |                                       | 4 ☐ Donation 5 ☐ Other (Specify   |                                 | Kes                | tnav             | en Cre           |                  |   | 2006               |           | lerick       |                     |                          |            |
| saitimore, | permit. Page: Department of Important: If if eny injury or pnce.  |                                       | 21. Signature of Edneral Service Licen  | is <del>oo</del>                | -                  |                  | Restha           | nd Addre<br>Ven  | ess of Facility<br>Funeral                | Services           | . Sk      | kot (        | v.bo:               | РΑ                       |            |
| -          | 70 = 0 a  |                                       | 1///////  |                                 |                    |                  | 9501 C           | atoc             | tin Mtn.                                  | Hwv. Fr            | eder      | ick.         | MD :                | 21701                    |            |
| <u> </u>   |   |                                       | 23 Perty Enter the diseese, o comp<br>shock, or heart failure.  | plications that caus            | ed the deat        | h. Do no         | t enter the mo   | de of dyi        | ng, such as cardia                        | c or respiratory a | rrest,    |              |                     | Approxima<br>Interval Be | ate        |
| F          | Physician   |                                       |   |                                 |                    |                  |                  |                  |   |                    |           |              | 1                   | Onset and                | Death      |
| Ĺ,         | /Medical  |                                       | Immediate Cause (Final disease or condition   | E                               | inds               | 199              | 1                |                  | adjor                                     | n. 2 cat           | 100       | )            | 1                   |                          |            |
|            | Examiner  |                                       | resulting in death)   | a                               | Due to (c          | res e co         | nsequence of)    | :                | asol of                                   | 190/91             | 10        |              | -                   |                          |            |
|            | Q #   | edical Examiner                       |   | _                               |                    |                  |                  |                  |   | /                  |           |              |                     |                          |            |
|            | or requires that the death certificate be executed been signed by the attending physician and should be datached for use as the burial-transit  | E                                     | Sequentially list conditions,   | D                               | Due to (o          | r es e co        | nsequence of)    |                  |   |                    |           |              |                     |                          |            |
| Š,         | oe ex   | Û                                     | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events                                     |                                 |                    |                  |                  |                  |   |                    |           |              | ŀ                   |                          |            |
| 00/90      | ate t   | 200                                   | that initieted events<br>resulting in death) Lest   | · .                             | Due to (o          | as e co          | nsequence of):   |                  |   |                    |           |              | 1                   |                          |            |
| 9          | a as  | E E                                   |   | d                               |                    |                  |                  |                  |   |                    |           |              | F                   |                          |            |
| _          | ath co  | 2                                     | _   | d                               |                    |                  |                  |                  |   |                    |           |              |                     |                          |            |
| 5          | at the death of by the attendated for us  | 300                                   | Part II. Other significant conditions co  | ontributing to death            | but not res        | ulting in t      | he underlying o  | ause gi          | ven in Pert I.                            | 23b. Did           | tobacco   | use contri   | bute to             | the cause                | of death?  |
|            | d by  |                                       |   |                                 |                    |                  |                  |                  |   | 10                 | Yes 2     | ENO 3        | ☐ Prob              | ably 4 □                 | Unknown    |
| 'n.        | as traigne  | 2                                     |   |                                 |                    |                  |                  |                  |   |                    |           |              |                     |                          |            |
|            | ine law raquiras that the sate has been signed by the page 2 should be datache.   | 20                                    |   |                                 |                    |                  |                  |                  |   | 24a. Was           | an autop  | sy 2         | avai                | e autopsy<br>lable prior | to         |
|            | as be   | 2                                     |   |                                 |                    |                  |                  |                  |   |                    |           |              | of de               | pletion of eeth?         | cause      |
| _          | the law<br>ata has t<br>paga 2 s  | 5                                     |   |                                 |                    |                  |                  |                  |   | 10                 | Yes 2     | OW           | 1 🗇                 | Yes 2□                   | ] No       |
| ַ          | entifica<br>ector,  |                                       | 25. Was case referred to medical examiner?  |                                 |                    |                  |                  |                  | 26. Plece of Dea                          | ath (Check only o  | ne)       |              |                     |                          |            |
| <u> </u>   | Attending Physician: at death. ector: After this certific by the funeral director.  | o                                     | 1 ☐ Yes 2 No  | Hospitel: 1 ☐ Inpat             | ient 2 🗆           | ER/Outp          | atient 3 D       | DA Oth           | ner: 42 Nursing H                         | lome 5 Resid       | dence (   | 3 □Other     | (Specify)           |                          |            |
| <b>O</b>   | ter th  |                                       | 27. Manner of Death  → Naturel 5 ☐ Pending  | 28e. Date of In                 | ury<br>ev Year)    | 28b. Tin<br>Inju | ne of            | 28c. Inju        |   | 28d. Describe      |           |              |                     |                          |            |
| 2          | ha for  |                                       | 2 ☐ Accident investigation  |                                 |                    |                  | м                |                  | Yes 2 □ No                                |                    |           |              |                     |                          |            |
| <u> </u>   | al or attending P   |                                       | 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of I                 | njury - At ho      | me, farm         | , street, factor | y, office        |   | 28f. Location (    | Street an | d Number     | or Rural            | Route Nun                | nber,      |
| 5          | as affer of in the control of | ֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓ |   |                                 | , , , , ,          |                  |                  |                  |   |                    | , 0.2.0,  |              |                     |                          |            |
|            | n 24 hou<br>n 24 hou<br>ne Funer<br>pletaly fil   | 5                                     | 29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam   | ysician: To the bes             | of my kno          | wiedge, o        | leath occurred   | at the tir       | ne, date and place                        | , and due to the   | cause(s)  | end mann     | er es sta           | ted.                     | -)         |
|            |   | _                                     |   | and manner s                    | tated.             |                  |                  |                  |   | med at the time,   | uate and  | place, and   | aue to t            | ne cause(                | 5)         |
| ,          | With To the Control   | 2                                     | 29b. Signature and title of certifier   | 411                             |                    |                  | 29               | c. Licens        | e number                                  |                    | 29d. Dat  | e signed (A  | Month, D            | ey, Year)                |            |
|            | 1   |                                       |   |                                 |                    |                  |                  | D.               | 53165                                     |                    | 7         | - 5-1        | 00                  |                          |            |
|            | 5   |                                       | 30. Neme end address of person who  | completed cause of              | deeth (Item        | 23e) (T          | /pe, Print)      |                  |   |                    |           |              |                     |                          |            |
|            |   |                                       | James Lowenthal,  | M.D. 100                        | Hospi              | tal              | Dr., #           | 310,             | Prince                                    | Frederic           | k, M      | D 206        | 578                 |                          |            |
|            | State   |                                       | 21 Date filed (Month Day Veste)   |                                 | rer's Signa        |                  | 1                |                  |   |                    |           |              |                     |                          |            |
|            | Registrar   |                                       | 005 - 0 4   | 12.4                            |                    |                  | All Carlot       | P                |   |                    |           |              |                     |                          |            |

DHMH 16 Rev 6/95

### VOID

# CERTIFICATE #

2004-22997

## SEE

# **CERTIFICATE #**

2006-21909

Deceased Name- Alfred Let Finnel)
Completed August 30, 2006 Jinuxi Jaylon

|             |  |                | 1 - For State Registrar   | tate of Maryland  |                               | artment of H   |                                  | -  | giene<br>Reg. No. 2            | 006                              | 22998   |  |
|-------------|--|----------------|---|---|-------------------------------|--|----------------------------------|--|--------------------------------|----------------------------------|---|--|
|             | Physici  |                | 1. Decedent's Name (First, Middle, Last) Blannie C. Fr  | reeman  |                               |  |                                  | 2. Date of De<br>Month<br>Julv   | Day                            | Year<br>2006                     | 3. Time of Death 9:15 A M                     |  |
| 'A          | /Medio<br>Examir   |                | 4a. Facility Name (If not institution, give stree<br>Mallard Bay Nurs   | stand number)<br>Sing Home  |                               |  | bridge                           | eath   | 4c. Cour                       | rches                            |   |  |
|             | Funeral<br>Director  |                | 5. Social Security Number 074-20-8123  Usual Residence of Decedent  6. Sex 1 □ M  | 7. Age (In yrs. last 9 2  | birthday)<br>Yrs.             | If Under 1 Year<br>Months Days   | If Under 24 h                    | fin. (Month. Da  | v. Year)                       | 9. Birthpl<br>Count<br>North     | lace (State or Foreign<br>try)<br>Carolina    |  |
|             | h the Maryland<br>r 28a-f show   | Director       | 10a. State         10b. County           MD         Dorchest           10e. Street and Number   | 10c. City, To   | own or Lo                     | Hurlock  | ζ                                |  | 10g. Citizen o                 |                                  | 0d. Inside City Limits 1 ☐ Yes 2 ☑ No try?    |  |
| 92          | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Healin and Mental Hygiene. It is the marked other than "natural", or items 23e or 28e-f show if itims 7 is marked other than "natural", or items 23e or 28e-f show or other traumatic avent, the Medical Expirient must be notified at | Funeral        | 1 Never Married 2 Married 1   | Nas Decedent Ever in U.S.<br>Armed Forces?<br>I ☐ Yes 2 ☑ No<br>If Yes, Give                        |                               |  | spanic Origin?<br>n, Mexican, Pu | (Specify Yes or No<br>lerto Rican, etc.)   | United<br>14. R<br>8           | lace - America<br>lack, White, e | an Indian,<br>etc.                            |  |
| 21215-0036  | vithin 72 hours<br>ne.<br>han "natural",<br>n Medical Ex.  | Completed by   | 15. Decedent's Educatio (Specify only highest grade cor   | Year or Dates: on   | 6a. Deced<br>(Give<br>life. L | lent's Usual Occupa<br>kind of work done of<br>OO NOT use retired,<br>Stic Wor | ation<br>furing most of          | working  | 16b. Kind of                   | Business/Ind                     | lustry  |  |
| Maryland 2  | should be filed wind Mental Hygie a marked other turnatic avent, the   | To Be Co       | 17. Father's Name (First, Middle, Last)  James Carter   |   |                               |  | 18. Mother's I                   | Name (First, Middle,   | , Maiden Sumi                  | ame)                             |   |  |
|             | and 2 shole eaith and Mm 27 is me  |                | 19a. Informant's Name/Relationship (Type, Print)  Mildred Cephas/Daughter  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code)  6740 Bobtown Rd., Hurlock, MD 21643 |   |                               |  |                                  |  |                                |                                  |   |  |
| Baltimore,  | t. Pa<br>rtmen<br>rtant:   |                | 20a. Method of Disposition  pCPBurial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  | oval from State   | tery, cren<br>:a1 H           | sition (Name of natory or other place ill Cem.                                 | 07                               | Date / 19/06   | Feder                          | n - City or Tov<br>alsbu         | irg, MD                                       |  |
| Ba          | Depe<br>Impo<br>any ir   | 5 3            | 23a. Part . Enter the disease, or complication  | Coale   |                               | TO IN TIEL   | III DL.,                         | rederats   | spurg,                         | MD 210                           | me, P.A. 32 Approximate                       |  |
|             | Physician<br>/Medical<br>Examiner  |                | shock, or heart failure. List only one ca<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)  a   | Due to (or as a consequence   | stiv                          | 0  | 1                                | nyopA  | 11                             | 1                                | Interval Between<br>Onset and Death<br>MoNTLS |  |
| 8760,       | The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit   | dicai Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d  | Due to (or as a consequence   |                               |  |                                  |  |                                |                                  |   |  |
| .O. Box 6   | thet the death certific<br>ed by the attending p<br>detached for use as  | Physician/Me   | in the past 12 months?  | f yes, outcome of pregnancy<br>1 Live birth 2 Fetal dea<br>4 Pregnant at time of death<br>9 Unknown |                               | Ectopic pregnancy<br>Other (specify)   |                                  |  |                                | Date of deliver                  | y<br>Day Year                                 |  |
| rds, P      | w requires thet<br>been signed t<br>should be det  |                | Part II. Other significant conditions contribu  | Accident,   | g in the un                   |  | n in Part I.<br>NSI 04           | 23e. Did to  |                                | ontribute to the                 | e cause of death?                             |  |
| al Records, | : The law recete hes be<br>; page 2 sh   | Completed by   | Dsteonythritis,<br>Iron Deficien  | Ischemic<br>acy Aneuni  |                               | sowel ]  | Disens                           | perfor   | an 24b<br>sy<br>rmed?<br>22 No | death?                           | sy findings available apletion of cause of    |  |
| n of Vital  | Attending Physician: The la<br>in death.<br>actor: After this certificate has<br>by the funeral director, page 2   | on: To Be      | 25. Was case referred to medical examiner?  1  Yes 25 No Hospi  27. Manner of Death  1. Natural 5 Pending   | 1 ☐ Inpatient 2 ☐ ER/   | Outpatient  Time of Injury    | 28c, Injury  | 1: 4 Mursing                     | Death Check only on the property of the proper | dence 6 🗆 O                    |                                  | )   |  |
| Division of | To the Hospitel or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral  | Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined 28   | Be. Place of Injury - At home, building, etc. (Specify)   | farm, stre                    |  | ′es 2 □No                        | 28f. Location (5<br>City or Tow  | Street and Nun<br>vn, State)   | nber or Rural                    | Route Number,                                 |  |
|             | the Hospi<br>in 24 hour<br>the Funer<br>upletely fill  | Medical        | one) 2 Medical Examiner:  | n: To the best of my knowled<br>On the basis of examination and manner stated.                      | lge, death<br>and/or inv      | estigation, in my op   | inion, death or                  | courred at the time, o   | date and place                 | a, and due to t                  | the cause(s)                                  |  |
|             | To<br>with   |                | 29b. Signature and title of certifier   | _ D.O.  | 1 (7)                         |  | 46/S                             |  | 29d. Date sign                 |                                  | •   |  |
|             | Sta  | te             | 30. Name and address of person who comple Lots A. Na R. R. 31. Date filed (Month, Day, Year)  | ated cause of death (Item 23a<br>32 Registrar's Signature   | 100                           | Brank  | ole St                           |  | 7/13                           | i dge                            | MD  |  |
|             | Registr  |                | 1111 1 4 2006   | Ab. M   | L                             | and the  |                                  |  |                                |                                  |   |  |

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month JUN 2006 Year LAUREN NICOLE GENTRY 25 9:14 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 June 25, 2006 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F Director n/a Bethesda, MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or itema 23a or 28a-f shov the Modeal Experient next be notified at Severn MD Anne Arundel 1 Yes 2 No Funeral Directo 10f. Zip Code 21144 10e. Street and Number 10g. Citizen of What Country? 1902 Sheffield Ct. USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes X No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A0 . Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tant: if Item 27 is marked other fulury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michelle Jones Gentry Amy T.ee Christopher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Lee Gentry Father 1902 Sheffield Ct. Severn, MD 21144 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Metro Crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: if any injury or once. 4 □ Donation 5 □ Other (Specify) June 28,06 Baltimore,MD 21. Signature of Funeral Service License Hardesty Funeral Home P.A. 851 Annapolis Rd Gambrills,MD 21054 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHONDROPLASIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 attending physicien Completed by Physician/Medical signed by the attending phys IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) O 9 Unknown 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2X No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has page 2 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Hospital: Other: 1 🛮 Inpatient 1 ☐ Yes 2 XNo 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA nours after death.

neral Director: After this
filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 27/2006 MD D-0061988 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER WESLEY HODGSON MC USN LT BETHESDA MD 20889-5600 31. Date filed (Month, Day, Year) egistrar's Signature State JUL 0 5 2006 Registrar

Ronald Edward Gardner

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

|  | _              | 1- For State<br>Registrar  |   | ficate of Death   |   | Reg No.                      | 705 2300  |
|--|----------------|--|---|---|---|------------------------------|---|
| Physicia   |                | Decedent's Name (First, Middle,Last)   |   |   | 2. Date of De<br>Month  | Day Year                     | 3. Time of Death  |
| Medical Exami  | ner            | Ronald Edward Garda Facility Name (if not institution, give  |   | 4b. City, Town, or Loca   | July 11,  | 2006                         | 1536 hrs  |
|  |                | 312 Severn Avenue Apartm   |   | Annapolis   | ation of Death  | 4c. County of I              |   |
| Funeral  |                | Social Security Number   |   |   | If Under 24Hrs 8. Date of B                                   | Birth(MM/DD/YYYY)            |   |
| Director   |                |  | M 2_F 53  |   | Lieuwe Min  | , 1953 <sup>F</sup>          | oreign Maryland   |
| any  | - 1            | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, To   | own or Location   |   |                              | 10d. Inside City Limits                                   |
| ž .  |                | Maryland Anne Ar   | un de 1 Ant   | napolis   |   |                              | 1 X Yes 2 No  |
| daryland<br>28a-f show<br>d at once.   | 읈              | 10e. Street and Number   | 11111   | 10f. Zip Code   |   | 10g Citizen of What          | Country?  |
| e, MD 21215-0036<br>I and 2 should be filed within 72 hours after death with the Maryland<br>Health and Mental Hygiene.<br>Titem 27 is marked other than "natural", or items 23a or 28a-f shorr traumatic event, the Medical Examiner must be notified at once   | I Director     | 312 Severn Ave Ap  |   | 21403   |   | United St                    | ates  |
| eath wit   | Funeral        | 11 Marital Status 1 Never Married 2 Married  | <ol><li>Was Decedent Ever in U.S.<br/>Armed Forces?</li></ol> | <ol> <li>Was Decedent of Hispan<br/>If Yes, specify Cuban, Me</li> </ol>              | iic Origin? ( Specify Yes or N<br>exican, Puerto Rican, etc.) | No- 14. Race - A<br>White, e | American Indian, 8lack,<br>etc.                           |
| ufter dea  | by Fur         | 3 Widowed 4 X Divorced   | 1 Yes 2 X No  | 1 Yes 2 X No sp   | pecify:   | Specify:                     | White   |
| Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner   |                | 15. Decedent's Education (Specify only   |   | <ol> <li>Decedent's Usual Occupation (<br/>during most of working life. DO</li> </ol> |   | 16b. Kind of 8usin           | ess/Industry  |
| 66<br>n 72 h<br>ian "r   | Completed      | Elementary/Secondary (0-12)  | College (1-4 or 5+)   |   | ,   | 0.16                         |   |
| 003<br>withi<br>giene<br>her th  | E              | 17. Father's Name (First, Middle, Last)  |   | Entrepren   |   |                              | Employed  |
| 215-0036<br>be filed within 7<br>ttal Hygiene<br>ked other than<br>ent, the Medica   | BeC            | Earnie Gardner, S  | r   |   | Mother's Name (First, Middle largaret Ford                    | , Maiden Surname)            |   |
| 212<br>ould be<br>Ment<br>mark<br>c ever   | 0              | 19a. Informant's Name/Relationship (Typ  |   | 19b Mailing Address (Street and   |   | umber, City or Town, 5       | State, Zip Code)  |
| MD<br>2 shc<br>th and<br>27 is   |                | Earnie Gardner, J  | r. / Brother  | 1914 Forest Dri   | ve Suite 2A   | Annapolis                    | , MD 21401  |
| Fe l and l Heal  |                | 20a. Method of Disposition  1 Burial 2 X Cremation 3   |   | ice of Disposition (Name of cemete matory or other place)                             | ery, Date   | 20c. Location - Ci           | ty or Town, State   |
| Baltimore, MD<br>permit. Pages I and 2 sh<br>Department of Health and<br>Important: If item 27 is<br>njury or other traumat  |                | 4 Donation 5 Other Specify:  | 1 Comovar nom Otato   | politan Cremato   | ry 7/16/2006  | Alexandr                     | ia, Virginia  |
| alti<br>rmit<br>ppartm<br>ports  | 1              | 21. Signature of Funeral Service License   |   |   |   |                              | ral Home, Inc.  |
| <b>™</b> 80 €.€  | 1.4            |  | لاي   |   |   |                              | lis, MD 21401   |
| Physician<br>/Medical  | Ì              | 23a. Part I, Enter the disease, or complice failure. List only one cause on each                     | cations that caused the death. D                              | o not enter the mode of dying, such<br>atherosclerotic card                           | h as cardiac or respiratory a<br>diovascular dise             | rrest, shock, or heart       | Approximate Interval<br>Between Onset and                 |
| Sxaminer   | 1              | failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) |   | ronic alcoholism  |   |                              | Death   |
|  |                | h  | ue to (or as a consequence of):                               |   |   |                              |   |
|  | ĕ              |  | ue to (or as a consequence of)                                |   |   |                              |   |
|  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated                                      | ue to (or as a consequence of):                               |   |   |                              |   |
| ansit  |                | events resulting in death) Last  | de to (or as a consequence or).                               |   |   |                              |   |
| 760,<br>Trate be executed<br>g physician and<br>the burial - transit   | Medical        | X UNPENDED   | AMENDED   | ME 050 0/2/00 B   |   |                              |   |
| 8760, tifficate be ng physic as the bur  | Mec            | IF FEMALE:   | 23c. If yes, outcome of pregnal                               |   |   | 23d Date of de               | livery  |
| 687<br>certific<br>ding<br>se as t   | ian/           | 23b. Was decedent pregnant in the past 12 months?  | Live birth     Pregnant at time of death                      | 2 Fetal death 3 E   | Ectopic pregnancy   | Month                        | Day Year  |
| Box 68 e death certi the attendin ed for use a   | Physician/     | 1 Yes 2 No 9 Unknown   | 9 Unknown   | 5 Other (Specify)   |   |                              |   |
| that the death certificated by the attending detached for use as   |                | Part II. Other significant conditions  | contributing to death but not resu                            | ulting in the underlying cause given  | n in Part I. 23e Did  | tobacco use contribut        | te to the cause of death?                                 |
| ords, P.O.   | d by           |  |   |   | 1Y  | es 2 No 3                    | Probably 4 Unknown  |
| ords, w requires been should   | Completed      |  |   |   | 24a. Was  |                              | re autopsy findings available r to completion of cause of |
| eco<br>ne law<br>te has  | Ĕ              |  |   |   | perf  | ormed? deal                  | th?   |
| Vital Reco<br>ysician: The law<br>his certificate has<br>director, page 2 s  | ğ              | 25. Was case referred to medical   |   | 26.Płace of D   | Death (Check only one)  | 2 10 1                       | Yes 2 No  |
| Vita<br>sysicia<br>chis ce<br>direct   | e e            | examiner?  1 ✓ Yes 2 No  | spital: 1 Inpatient 2 Ef                                      | R/Outpatient 3 DOA  | er Nursing Home 5   | Residence 6 🗸                | Other: Scene  |
| Division of Vital Records, rate or Attending Physician: The law requires after death at Director: After this certificate has been sted in by the funeral director, page 2 should   |                | 27. Manner of Death  | 28a. Date of Injury<br>(Month, Day, Year)                     | 8b. Time of Injury 28c. Injury at   |   | how injury occurred          |   |
| ion<br>ttendi<br>death<br>tor:   | Certification: | 1 XXNatural 5 Pending 2 Accident Investigation   |   | 1Yes  | 2 No  |                              |   |
| ivis<br>lor At<br>after d<br>Direct  | 븳              | 3 Suicide 6 Could not be   |   | e, farm, street, factory, office buildi   | ing, etc. 28f. Location or Town,                              | (Street and Number of State) | r Rural Route Number, City                                |
| Divi<br>spital or<br>hours afte<br>meral Dir   | Ö              | 4 Homicide determined  | (Specify)   |   | W.  |                              |   |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri | Medical        | one) 2 Medical Examiner:   |   | death occurred at the time, date at<br>for investigation, in my opinion, dea          |   |                              |   |
| E 3 E 9  | Me             | 29b. Signature and title of certifier  | Harrior stated  | 29c License nu  | imber   | 29d Date signed              | (Month, Day, Year)  |
|  |                | auch   |   | O.C.M.E   |   | July 12, 2006                |   |
|  |                | 30. Name and address of person who co  |   | ,   |   | <u> </u>                     |   |
|  |                |  |   | 1 Penn Street, Baltimore,   | MD 21201  |                              |   |
| St<br>Regist   | ate<br>rar     | 31. Date filed (Month, Day, Year)  | 37 Registrar's Signature                                      | Smooth  |   |                              |   |